Media Clips

COVERED CALIFORNIA BOARD CLIPS
Aug. 7 – Sept. 10, 2019

Since the Aug. 6 board meeting, Covered California continued to get coverage about its lowest average rate change in history, while the agency, Gov. Newsom and the State Legislature received praise for actions combatting federal changes in health care policy. Nationally, the uninsured rate rose for the first time in a decade and health care costs continued to dominate the conversation.

PRINT
Articles of Significance

Santa Cruz Sentinel
www.santacruzsentinel.com

Covered California's 2020 average rate change, 0.8%, is smallest increase since 2014
Elaine Ingalls

SANTA CRUZ — The average rate for Covered California's coverage on the Central Coast will increase by 1% for the 2020 plan year, according to a press release. The 2019 average rate change for the Central Coast was 16%.

As of April, 26,000 residents in the Central Coast region use Covered California, according to James Scullary, Covered California's broadcast and media relations branch chief. In April 2018, the Central Coast had about 1,000 more consumers enrolled, he said. The Central Coast region includes Santa Cruz, Monterey and San Benito counties.

The average rate change for Covered California's individual market statewide is a 0.8% increase, the smallest rate change since Covered California started, according to the release. This is the lowest rate change since a 4% change for 2016. An estimated 1.4 million people are enrolled through Covered California, which has remained about the same the last few years, Scullary said. Rate changes could not be converted to dollar figures, he said.

"Health care [costs] is very local," said Scullary. Rates vary by region: they are based on where a consumer lives, income, age and health and how many customers are enrolled in health care in that area, he said.

This change is smaller than Covered California traditionally sees, Scullary said. There are two main reasons why insurance premium costs for 2020 are decreasing: state subsidies and a law, Senate Bill 78 Chapter 38, that requires consumers to purchase health insurance if they can afford it.

Covered California was established in 2014 under the Patient Protection and Affordable Care Act as an online marketplace to shop and compare health insurance from 11 companies. They include Anthem Blue Cross, Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, L.A. Care Health Plan, Molina Healthcare, Oscar, Sharp Health Plan, Valley Health Plan and Western Health Advantage. Covered California is the only place to get federal assistance to help

customers buy health insurance. It also helps people with low incomes determine if they are eligible for Medi-Cal. Prior to 2014, people went directly to insurance companies to purchase plans.

Anthem Blue Cross, Blue Shield of California and Chinese Community Health Plan are expanding their coverage area, according to the release. This gives consumers more plan options, Scullary said. As insurance companies try to attract buyers and more people enroll, companies will compete on lowering prices, which benefits buyers, he said. Anthem Blue Cross, which covers northern California, the Central Valley and Santa Clara County, is expanding to the Central Coast. The company did not offer coverage to the Central Coast for the 2018 plan year, Scullary said.

For the Central Coast, the average rate change for consumers who shop and switch to the lowest-cost plan in the same metal tier (bronze, silver, gold, platinum premium) is a decrease of 6.1%, according to the release. This means people will receive the same level of benefits with a potentially lower-cost premium.

“Covered California’s competitive marketplace puts consumers in the driver’s seat by giving them the power to save money by switching plans and maintaining the same level of benefits,” said Peter Lee, Covered California executive director in the release. “Our health insurance companies know that if they don’t have the lowest rates possible, they are going to lose consumers.”

California is the first state to provide state subsidies to middle-income consumers who previously did not qualify for financial help, according to Covered California. The state has also restored the law that requires consumers to get health insurance if the cost isn’t higher than a certain percentage of their income. If people don’t purchase insurance, they could pay a penalty minimum of $695 per adult or a maximum of about $2,100 per family. California’s Franchise Tax Board will be in charge of applying these penalties.

Covered California predicts 922,000 people will be eligible for a new subsidy program in 2020 that lowers the cost of their coverage, including 235,000 middle-income Californians who previously didn’t receive federal help, according to the release.

Consumers are expected to save money based on how much they earn compared to the federal poverty level, which is $12,490 per one-person-household for 2020 health coverage, according to The Finance Buff.

Single-person-households earning $49,960 to $74,940 will save an average of $172 on their coverage per month, which will help them save an average of 23% on their premiums, according to Covered California. Savings are averages and can apply to

any-sized household, Scullary said. Single-person households that earn $24,980-$49,960 will save an average of $15 on their coverage per month, which will help the household save an average of 5% of their premiums. For single-person-households who earn less than $17,236, their premiums will go down to $1 per month.

The proposed rate changes are still subject to final review, according to the release. Covered California consumers can renew their existing plans or sign up for the first time starting in October. Participants can stop enrolling in Covered California or decide to enroll in Medi-Cal year round.

The new state subsidies will only be available through Covered California. Financial aid will vary based on age, annual household income and regional health care costs.

Covered California draws more insurers after state moves to bolster Obamacare
Steven Findlay

Felicia Morrison is eager to find a health plan for next year that costs less than the one she has and covers more of the medical services she needs for her chronic autoimmune disease.

Morrison, a solo lawyer in Stockton, buys coverage for herself and her twin sons through Covered California, the state's Affordable Care Act, or Obamacare, insurance marketplace. Morrison, 57, gets a federal subsidy to help pay for her coverage and she said her monthly premium of $167 is manageable. But she spends thousands of dollars a year on deductibles, co-payments and care not covered by her plan.

"I would just like to have health insurance for a change that feels like it's worth it and covers your costs," she said.

Her chances are looking up after lawmakers in Sacramento acted to enhance Covered California for 2020: They added state-funded tax credits to the federal ones that help people pay for coverage. And they reinstated a requirement for residents to have coverage or pay a penalty — an effort to ensure that enough healthy people stay in the insurance pools to offset the financial burden of customers with expensive medical problems.

Those new policies appeal to insurers. They've responded by expanding operations in the state, enhancing competition and offering consumers more choices.

California's ACA exchange is not the only one benefiting from the renewed interest of insurance companies. Other states are expected to see more insurers enter or reenter their marketplaces next year. That's a critical signal, experts said, that the state-based marketplaces, which cover about 11 million people nationally, are becoming more robust and less risky for insurers — despite ongoing political and legal battles over the ACA.

"It's taken longer than expected, due in part to the political rancor, but things seem poised to go well for next year," said Katherine Hempstead, a senior policy advisor at the Robert Wood Johnson Foundation. "The ACA market is becoming a better place for insurers and consumers."

Hempstead said 2020 would probably be the second year in a row with a net increase in the number of insurers participating and relatively modest premium increases nationwide.

Covered California said last month it expected an average premium increase of just 0.8% in 2020, far below this year's hike of nearly 9% and the lowest since the agency began enrolling people in October 2013.

Peter Lee, Covered California's executive director, attributed next year's slender rate increase to the new state-funded premium subsidies and the requirement that people be insured.

California is one of a handful of states offering its own subsidies to residents — and the first to provide them to people making more than the federal income threshold of 400% of the federal poverty level. The subsidies are available to people earning up to 600% of the poverty level, which are individuals making up to about $75,000 a year and families of four with an annual income up to $154,500. The extra aid is expected to help 235,000 families who didn't previously qualify for federal help.

California insurers have responded enthusiastically.

Anthem Blue Cross, which withdrew from most of the state's individual market in 2018, is jumping back in. It will expand offerings in the Central Valley and return to the Central Coast, Los Angeles County and the Inland Empire. Anthem health plans will be available to nearly 60% of Californians next year, according to Covered California.

Blue Shield of California will also expand its HMO plan into parts of Tulare and Riverside counties and add coverage in Kings and Fresno counties. And the Chinese Community Health Plan will expand to cover all of San Mateo County next year.

“Nearly every Californian will be able to choose from two carriers, and 87% will have three or more choices in 2020,” Lee said. He urged people to shop among plans, including the new ones, to try and lower their premiums.

Anthem, the nation’s second-largest health insurer with 40 million enrollees in 10 states, also plans to expand its ACA coverage in Virginia next year.

Centene, which has 12 million enrollees nationwide, plans to expand into new ACA markets next year, a company representative said. It operates in 20 states, three of which it entered for the first time this year.

Two startup insurers, launched in recent years in part to serve the ACA marketplaces, also plan expansions in 2020. Bright Health, based in Minneapolis, announced in late July that it will offer ACA plans in six more states, on top of the four it now serves. And New York-based insurer Oscar, which this year offered ACA plans in nine states, including California, plans to enter Colorado, Pennsylvania and Virginia, as well as new areas of New York and Texas.

Participation rates matter. A 2017 study by researchers at the Urban Institute found that the median monthly ACA premium that year was $451 in areas with one insurer compared with just over $300 in markets with three to five insurers and $270 in those with six or more insurers.

The number of insurance companies offering plans in ACA marketplaces has fluctuated. From 2014 to 2016, the average number was between five and six, according to the Kaiser Family Foundation. That number declined to 3.5 last year, following Republican threats to gut or replace the ACA and Trump administration changes to the marketplaces. (Kaiser Health News is an independent program of the foundation.) Premiums in some areas rose 20% to 30%.

This year, the average number of plans ticked up to four.

But variability among states is still substantial. Four states — Alaska, Delaware, Mississippi and Wyoming — have just one ACA insurer this year. In contrast, seven states — California, Massachusetts, Michigan, New York, Ohio, Texas and Wisconsin – have eight insurers or more.

“Anything less than three is not a good situation,” said Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University in Washington. “It looks like the marketplaces are stabilizing, though, and importantly the insurers are now making more money in this market.”

Kelley Turek, the director of commercial insurance at America's Health Insurance Plans, the main trade group for health insurance companies, agreed. "The churn is finally slowing down," Turek said. "Companies are staying and expanding into new geographical areas. We strongly agree the market works best when consumers have more choice."

The ACA marketplaces still need more regulatory predictability, however, and political divisiveness over the ACA continues to undermine that, Turek said.

A federal appeals court in New Orleans heard testimony last month on a challenge to the constitutionality of the ACA brought by Texas and 17 other mostly Republican-led states. The states argue that when Congress eliminated the tax penalty for not having insurance, it invalidated the entire law.

THE UNION

Covered California: More affordable health-care options than ever for northern counties
Staff

Health insurance coverage will be more affordable than ever before for many people in northern counties thanks to new financial help and competitive rates, a news release states.

Covered California announced the rate change for the region will be -1.7 percent in 2020, which is lower than the statewide average increase of 0.8 percent. According to the release, consumers will pay less than they are paying now, by an average of -8.4 percent, if they shop around and switch to the lowest-cost plan in the same metal tier.

Also new for 2020, the state of California is making more financial help available to consumers through a new subsidy program that will further lower the cost of coverage.

"Even before considering the positive impact of new state subsidies, many Californians will be seeing little change or even decreases in their underlying premiums, said Covered California Executive Director Peter V. Lee.

People who fall within the following income brackets could be eligible for the new financial assistance.

People whose annual household income is less than $17,237 for an individual and $35,535 for a family of four. They will see their premiums for the benchmark plan lowered to $1 per member, per month.

People whose annual household income is between $24,980 and $49,960 for an individual, or between $51,500 and $103,000 for a family of four. They could be eligible to receive an average of an additional $15 per household per month, in addition to any federal financial help they may get.

Middle-income Californians whose annual household income is up to $74,940 for an individual or $154,500 for a family of four. These consumers previously did not qualify for federal financial help because they exceeded income requirements. They could be eligible to receive an average of $172 per household, per month, which will help them save an average of 23 percent off their current premiums. Many of these consumers, particularly those who live in high-cost regions, will see significant savings with annual reductions in their health care premiums in the hundreds and even thousands of dollars.

“California continues to lead the way in this new era of health care,” Lee said. “This first-first-in-the-nation program will make coverage more affordable for many middle-income Californians, such as small-businesses owners, entrepreneurs and contractors.”

The most recent data shows there are more than 51,590 Covered California consumers in the northern counties. Depending on zip code, people in these counties will once again be able to choose plans from Anthem Blue Cross, Blue Shield of California and Kaiser Permanente. All 11 carriers will continue offering products across the state in 2020, and Anthem Blue Cross will expand. That means 87 percent of Californians will be able to choose from three carriers or more, the release states, and 99.6 percent of consumers will have two or more choices.

Consumers can find out what they will pay for their 2020 coverage starting during the renewal period in October, when they can visit Covered California’s website at http://www.CoveredCA.com and begin using the Shop and Compare Tool for 2020.

Consumers who do not have health insurance will be able to begin signing up for 2020 coverage in the fall. Others with special qualifying life events, like losing their coverage or moving, can enroll year-round. Medi-Cal enrollment is also year-round.

Interested consumers should go to http://www.CoveredCA.com to find out if they qualify for financial help and find free local help to enroll. They can contact the Covered California service center for enrollment assistance by calling 800-300-1506.

THE FOOTHILLS Sun-Gazette

Valley customers to see stark reduction in medical plan rates
Staff

TULARE COUNTY—When it comes to California health care, Valley counties are getting a significant break in 2020.

According to Covered California, health insurance coverage will be more affordable than ever for many people in San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties thanks to new financial help and competitive rates.

Covered California announced the rate decrease for the region will be -5.7% next, while the rest of the state will see a statewide average change of 0.8%. Point eight percent is the lowest change since Covered California's launch, due to new state affordability initiatives designed to lower costs and encourage enrollment, stated a Covered California news release last month.

For those in the Valley, more importantly, consumers will pay less than they are paying now, by an average of -9.3%, if they shop around and switch to the lowest-cost plan in the same metal tier.

Also new for 2020, the state of California is making more financial help available to consumers through a new subsidy program that will further lower the cost of coverage.

"Even before considering the positive impact of new state subsidies, many Californians will be seeing little change or even decreases in their underlying premiums," said Covered California executive director Peter V. Lee.

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• People whose annual household income is less than $17,237 for an individual and $35,535 for a family of four. They will see their premiums for the benchmark plan lowered to $1 per member, per month.

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“California continues to lead the way in this new era of health care,” Lee said. “This first-in-the-nation program will make coverage more affordable for many middle-income Californians, such as small-business owners, entrepreneurs and contractors.”

The most recent data shows there are more than 71,000 Covered California consumers in the San Joaquin Valley. Depending on their ZIP code, people in these counties will once again be able to choose plans from Anthem Blue Cross, Blue Shield of California, Health Net and Kaiser Permanente.

All 11 carriers will continue offering products across the state in 2020, and Anthem Blue Cross will expand. That means 87 percent of Californians will be able to choose from three carriers or more, and 99.6 percent of consumers will have two or more choices.

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Los Angeles Times

Column: California shows all states how to protect patients from Trump's attacks on Obamacare
Michael Hiltzik

Covered California, the state's Affordable Care Act exchange, announced some good news a few weeks ago.

On July 19, the exchange said average premiums on its health plans would rise an average of 0.8% for 2020, the lowest annual increase in its history. In some regions, rates would increase even less or fall; customers who shop around when enrollment for 2020 plans opens on Oct. 15 could reduce their premiums by as much as 16.5%, depending on their home location, the exchange said.

Meanwhile, three of the 11 insurers participating in the Covered California exchange, including giant Anthem, said they would expand their footprint in the state. As a result, the exchange said, more than 99% of Californians will be able to choose from two carriers or more for insurance in 2020.

Next year will also bring larger premium subsidies for most California ACA enrollees and — unique to the state — subsidies for households with income up to about $154,500 (for a family of four), compared to the $103,000 cutoff established by federal law.

This record shows not merely that a single state can protect the stability of its individual health insurance market in the face of determined sabotage at the federal level. It also shows other states how to do so, and teaches that investment in the ACA can pay for itself in lower premiums for residents, higher federal reimbursements, and lower overall healthcare spending.

Most of what California has done to keep its marketplace functional and stable is within the capability of any state. California expanded Medicaid (known in the state as Medi-Cal) under the ACA, taking advantage of the federal government's 100% share of the expense from 2014 through 2016. The federal share is now 93%, and will drop to 90% for next year and beyond.

The state outlawed noncompliant insurance policies such as short-term plans, which rattled insurers and threatened to drive premiums higher by siphoning off younger, healthier customers seeking the cheaper rates that come from bare-bones benefits.

Covered California, meanwhile, negotiated the design and fees of health plans directly with insurance carriers so the plans would be standardized and the system easy for users to navigate. The exchange also aggressively promoted its individual plans with a marketing and outreach budget that reached $121 million in the current year, with the aim of enrolling the maximum percentage of eligible buyers. California's uninsured rate fell to 7.7% in 2018, a drop of nearly 10 percentage points since the pre-Obamacare year 2013, nearly double the rate of decline in the nation as a whole.

"We used to refer to the individual market as the Wild West," says Deborah Kelch, executive director of the Sacramento-based Insure the Uninsured Project. "There were no meaningful controls. For the individual market, the ACA was a complete game changer, and California went full in."

California could not insulate itself entirely from the vicissitudes of the ACA market or President Trump's campaign to sabotage the law. That campaign has included the promotion of bare-bones insurance plans, cutbacks in marketing and outreach, and constant threats to repeal the law.

After relatively modest premium increases of about 4% in 2015 and 2016, rates spiked by 13.2% in 2017. In part this reflected the end of a reinsurance program that had been designed to protect insurers from unexpected coverage costs only through 2016, when they were still feeling their way around the risk profile of a new, unfamiliar customer base.

Premiums rose by 12.5% in 2018, reflecting confusion over the ACA's future created by congressional Republicans' efforts to repeal the law and Trump's numerous efforts to undermine its effectiveness.

California's approach differs from that of other states that are rolling the ACA back, with the connivance of the Trump administration — for instance by imposing work rules and premiums on Medicaid or allowing insurers to sell limited-benefit health plans. These pound-foolish steps don't even qualify as penny-wise, since they can end up costing a state more for less coverage.

But its approach aims to "signal to policy makers across the nation that you can build on and improve the ACA," says Covered California Executive Director Peter V. Lee.

The state's most important initiatives are aimed at insulating the state from federal policies undercutting the ACA.

California is not alone in building a wall against the assault on the ACA by Trump and the GOP — 13 other states have enacted at least some provisions to stand their

ground. But “California is clearly setting the pace for ACA preservation,” Obamacare expert Charles Gaba observed in June, after a session in which the Legislature enacted more than a dozen protective bills.

Consider the state’s rule on short-term insurance plans. These are junk insurance plans that evade the ACA’s consumer protections; among other features, they can reject applicants for preexisting conditions. Under the Obama administration, these plans were limited to three-month nonrenewable terms. Trump wants to allow them to be sold for terms of up to a year, with unlimited renewals.

In California, short-term plans were made illegal as of last Jan. 1, on the reasoning that individual buyers needing short-term coverage because they’ve lost a job or are changing employers can sign up for Covered California all year long instead of making do with inferior coverage.

Insurers aren’t blind to the state’s commitment to a stable marketplace. Blue Shield of California, which already offers standard health insurance through Covered Calfornia statewide, says it decided to expand its HMO to two additional counties from the current 24, partially in recognition of the “proactive steps the state Legislature is taking to support affordable coverage in California.”

The other expanding insurers are Anthem, which will expand from Northern California, Santa Clara County and the Central Valley into the Central Coast, parts of the Central Valley, Los Angeles County and the Inland Empire, and Chinese Community Health Plan, which will expand into all of San Mateo County.

The state’s most important initiatives were enacted earlier this year. These were the reinstatement of the individual penalty for not carrying insurance and an expansion of premium subsidies.

The first was a response to the reduction of the federal penalty to zero, a provision of the Republican-passed tax cut bill of December 2017. The ACA’s drafters had designed the penalty to raise the cost of going without insurance, thereby encouraging more young and healthy people to buy. The ACA’s drafters considered it a pillar of the law because that cohort generally has lower medical expenses, so their premiums help subsidize coverage for everyone else and moderate premiums.

The penalty removal, which was effective last Jan, 1, had a measurable impact on enrollment, experts have found. Covered California blamed its 24% drop in new enrollments for 2019 (by more than 92,000 enrollees) almost entirely on the penalty’s elimination. “Even robust marketing cannot offset the negative impact of its removal,” the exchange said.

“Bringing back the penalty is, in essence, playing defense,” Lee told me. “It’s saying that we will do everything we can in this state to counter federal policy.” The state penalty will match what the federal penalty was before Republicans zeroed it out — 2.5% of household income or $695 per adult, whichever is greater, with a family maximum of about $2,100. (That was done to keep matters simple “if the federal government comes to its senses and reinstates the penalty,” Lee says.)

Expanding the premium subsidy is a different case. That’s designed to rectify a known flaw in the Affordable Care Act itself. The act provides premium subsidies for households with income up to 400% of the federal poverty line, or up to $103,000 this year. For income above that, the subsidy drops instantly to zero in what’s known as the subsidy cliff.

“The cliff at 400% is part of the original Affordable Care Act,” Lee says. “If, in the last six years of the Obama administration, Congress had been doing its job and talking about how to improve the law, we would have taken this up years ago. Instead, California is doing it now.” (Indeed, Hillary Clinton talked about making such a change during her presidential campaign.)

The state’s initiative will provide subsidies for households with income between 400% and 600% of the federal poverty level, or up to about $154,500 for a family of four this year. These are the people who feel left behind by the Affordable Care Act. They don’t get subsidies, so they’re fully exposed to every premium increase. And they’ve been abandoning the ACA system in droves — according to a new government report, unsubsidized enrollment fell by 2.5 million, or 40%, from 2016 through 2018. Expanding the subsidy will keep more of them insured.

The state also will augment the federal subsidy for households earning between 100% and 400% of the poverty line.

That will translate into an average subsidy of about $172 per month for households in the 400%-600% range, reducing their premiums by about 23%, according to the exchange. Buyers in the 200%-400% category will receive an additional $15 per household per month over the existing subsidy. Consumers earning less than 138% of the poverty level who enroll in Covered California rather than Medi-Cal will pay premiums of $1 per member per month.

Covered California expects these initiatives to produce about 187,000 new enrollments for next year, in part because customers will have to sign up through the exchange to get the subsidies rather than buying a plan separately. The subsidies will cost about $420 million in 2020, of which about $300 million would be offset by income from the

penalty. But the gains would be felt more broadly — some 235,000 Californians with middle incomes will become eligible for premium subsidies for the first time and 687,000 others will become eligible for more assistance.

In short, California is showing that the best way for a state to fight the Trump administration is to stick to its own rules and regulations, based on solid evidence of what works and what's right.

The campaign to bring affordable coverage to California residents may not be over. "These are tremendous steps forward," says Laurel Lucia of the UC Berkeley Labor Center, "but there are still individual Californians who struggle to afford health plans." Many are members of a largely overlooked group, families with incomes that place them just beyond the reach of premium subsidies.

"Covered California continues to be a leader in showing how a state marketplace can be effective," says Gerald Kominski, a health policy expert at the UCLA Fielding School of Public Health. "It's a beacon for the rest of the country."

Capitol Weekly's Top 100: Ten years and counting
Staff

A lot has changed in California politics over the last ten years. We have gone from a novice celebrity governor to a seasoned hand to our first Gen X executive. We've seen record budget deficits and record surpluses. We have transitioned to a plurality Latino state and have seen the gap between haves and have-nots grow larger than ever before.

During that time, Capitol Weekly has changed, too. We've gone from 'that print rag that publishes everyone's salary' to 'that Web site that publishes the list.'

Ahh, the list.

Sure, the names in the halls of power have changed, but the list abides. The definition of housing crisis has morphed from mortgage foreclosure to record homelessness, but the list abides. We've seen Brannan's become Chops, then the Diplomat (for a bit longer at least), but through it all, the list abides.

And so does Capitol Weekly. Amid the ever changing media landscape in our once provincial state Capitol, Capitol Weekly has navigated a journey of its own. When we started this enterprise, tweeting was the providence of the aviary set. Now, everyone and their grandmother is doing it.

As for the list, it's 10 years old and counting, and it may well outlive is all. When we first started it, we wanted a nice round number, but consciously never said what the list itself was. 100 what exactly? We couldn't say. But others filled in the gaps with assumptions of their own. And while the list has come under its share of criticism over the years — some of it justified — we have made tweaks and modifications.

But the spirit of the thing lives on.

This year's edition has lots of new names and faces that come with a new administration. We know we will be blasted for omissions and misrankings. But you may learn a name or two you didn't know before. And surely the list as a talk piece — even as something to rail against — is half the fun of the thing. As to whether your name or your selection belongs on this list of 100, I would ask you, 100 what exactly? Who's to say who belongs and who does not?

But that's what these lists do — they offer a mirror of our little world, filled with that intriguing stew of public service, ideological force and narcissistic drive. That is what makes our political community the frustrating and exhilarating amalgamation that it is.

So raise a glass to the list, imperfections be damned. Let's celebrate and illuminate the thing itself and reaffirm, once again, that right, wrong or otherwise, The List abides.

Enjoy.

–Anthony York, former editor, Capitol Weekly

More notes on this year's Top 100:

This list sets a record: We've never bothered so many people on their vacations in our hunt for information – from the Plumas National Forest to the Russian River to Stinson Beach to Guerneville to Hollywood to Oregon – we got 'em all. That'll teach them not to carry their cell phones.

A decade has passed since we did our first list in 2009 and a lot has changed — including the list. It started out as a lark but is no longer, and that's too bad: If there's anything we need putting this list together, it's fun.

The biggest change, of course, was the arrival of a new administration, complete with a clutch of new staff members in positions at the executive levels close to the governor. Keeping track of them is a full-time chore in itself.

There are more positions than before: There appears to be redundancy and the fancy titles often don't match the function – a problem not only in government but in the private sector, too. "Deputies" appear to be sprouting like mushrooms in the dark.

This is all reflected in this unusual roster, but it posed challenges for an outsider trying to track down information about the inner workings of the newly staffed Horseshoe.

The list has old names, new names and returning names. It also has a person whose name is very familiar to readers of this list but who has never been on it before. This is called a riddle, and we'll let you figure it out.

Generally, we're happy with our little compendium. It has a little better balance of gender and ethnicity than last time around, and a number of people who should have been on earlier finally got on.

We are certainly grateful to those people who sat down with us over the past four months at various coffee shops to chat and offer advice. Okay, so we ignored most of that advice, but it was nice of them, anyway.

Some caveats.

The list isn't anything other than subjective, although we solicit diverse opinions. We've had – and still have – board members on our list, but many were on the list before we ever had a board. All conversations involving this list are confidential, we discourage emails and we don't leak it. (We understand one person may have, and he knows who he is; we'll fix him). We don't have a hidden agenda to promote certain people over others.

But in the end, it was a labor of love and we hope you enjoy it. For a more artful look at the list, don't miss the note above from former editor Anthony York, who was there at its birth.

Enough prologue. On with the list…

–John Howard, editor, Capitol Weekly

(Click on a name to view the individual profile, including illustration)

28. Peter Lee
It seems like Peter Lee's battles never end. As executive director of Covered California, the state's version of the Affordable Care Act, Lee has faced controversy for years over health care coverage, rising costs, eligibility, federal funding cutoffs, expansion – you name it. This year is no different: President Trump, again, has vowed to repeal and replace the ACA, and he wants to permanently remove the requirement that people get coverage or face a penalty. The governor and Legislature oppose Trump, and Lee has likened the penalty to seat belt safety: You either buckle up or pay a fine. Removing the penalty forces rates up, and they tend to rise, anyway. Lee has been executive director for eight years, and before that he served in the Obama administration as ranking Medicare and Medicaid official, and he also worked under former Health Secretary Kathleen Sibelius.

Shop and save on health insurance in 2020
Staff

SACRAMENTO – Health insurance coverage will be more affordable than ever before for many people in San Diego County thanks to new financial help and competitive rates.

Covered California announced the rate increase for the region will be 0.2 percent in 2020, which is lower than the statewide average change of 0.8 percent. More importantly, consumers will pay less than they are paying now, by an average of -11.4 percent, if they shop around and switch to the lowest-cost plan in the same metal tier.

Also new for 2020, the state of California is making more financial help available to consumers through a new subsidy program that will further lower the cost of coverage.

"Even before considering the positive impact of new state subsidies, many Californians will be seeing little change or even decreases in their underlying premiums, said Covered California Executive Director Peter V. Lee.

People who fall within the following income brackets could be eligible for the new financial assistance.

• People whose annual household income is less than $17,237 for an individual and $35,535 for a family of four. They will see their premiums for the benchmark plan lowered to $1 per member, per month.

• People whose annual household income is between $24,980 and $49,960 for an individual, or between $51,500 and $103,000 for a family of four. They could be eligible to receive an average of an additional $15 per household per month, in addition to any federal financial help they may get.

• Middle-income Californians whose annual household income is up to $74,940 for an individual or $154,500 for a family of four. These consumers previously did not qualify for federal financial help because they exceeded income requirements. They could be eligible to receive an average of $172 per household, per month, which will help them save an average of 23 percent off their current premiums. Many of these consumers, particularly those who live in high-cost regions, will see significant savings with annual reductions in their health care premiums in the hundreds and even thousands of dollars.

“California continues to lead the way in this new era of health care,” Lee said. “This first-first-in-the-nation program will make coverage more affordable for many middle-income Californians, such as small-businesses owners, entrepreneurs and contractors.”

The most recent data show there are more than 109,130 Covered California consumers in San Diego County. Depending on their ZIP code, people in this county will once again be able to choose plans from Blue Shield of California, Health Net, Molina Healthcare, Sharp Health Plan and Kaiser Permanente.

All 11 carriers will continue offering products across the state in 2020, and Anthem Blue Cross will expand. That means 87 percent of Californians will be able to choose from three carriers or more, and 99.6 percent of consumers will have two or more choices.

Consumers can find out what they will pay for their 2020 coverage starting during the renewal period in October, when they can visit Covered California’s website at http://www.CoveredCA.com and begin using the Shop and Compare Tool for 2020.

Consumers who do not have health insurance will be able to begin signing up for 2020 coverage in the fall. Others with special qualifying life events, like losing their coverage or moving, can enroll year-round. Medi-Cal enrollment is also year-round.

Interested consumers should go to http://www.CoveredCA.com to find out if they qualify for financial help and find free local help to enroll. They can contact the Covered California service center for enrollment assistance by calling (800) 300-1506.

Bill Addressing Lapses in Coverage for Californians Using Covered California Heads to Governor's Desk
Staff

Sacramento, CA – Assemblymember Rebecca Bauer-Kahan's (D-Orinda) AB 1309 passed off the Assembly floor and now heads to Governor Gavin Newsom's desk. AB 1309 shifts the existing open enrollment period by 15 days, and eliminates lapses in coverage for those who purchase health insurance through the Covered California Health Exchange or the individual health exchange market.

This past year, California shifted the end of the open enrollment period from January 31st to January 15th for those who seek coverage under the Affordable Care Act (ACA). This shortened time period resulted in a precipitous drop in new enrollment by 24%. Bauer-Kahan's bill would shift the date back to January 31st. This allows individuals and families extra time to enroll after the conclusion of the hectic holiday season to choose the plan that is best for themselves and their families.

Additionally, under AB 1309, February 1st will be the effective date of coverage for those who purchase insurance. This eliminates the existing 2 week gap in coverage currently in place. Consumers currently suffer under a system where they purchase coverage, but don't see that coverage kick in for weeks. This bill was supported by Health Access California and over a dozen other healthcare advocate groups.

"Lapses in coverage when purchasing insurance on the individual market keeps Californians vulnerable and at risk for themselves and their families," said Bauer-Kahan. I'm proud that we addressed the lapses in coverage because when you pay for coverage – you should have access to care."

"As the Trump Administration continues to seek ways to sabotage the ACA, such as cutting the length of time people have to sign up for coverage, California is shoring up our individual market and making it work better for consumers," said Ronald Coleman, Director of Policy & Legislative Advocacy at Health Access California.

AB 1309 has received bi-partisan support in both houses and is the 6th bill that Assemblymember Bauer-Kahan has sent to the Governor's office.

The Washington Post
Democracy Dies in Darkness

Lindsey Graham promises Obamacare repeal if Trump wins and GOP takes back the House
Colby Itkowitz

Sen. Lindsey O. Graham (R-S.C.), one of President Trump's closest allies on Capitol Hill, vowed that Republicans will repeal the Affordable Care Act in 2021 if they win back the House and keep the White House.

Graham, who is up for reelection next year, told a conservative South Carolina radio show earlier this week that given the chance, Republicans will repeal the 2010 health-care law and replace it with something better. Earlier efforts by Republicans, including in the first two years of Trump's presidency when they held the House and the Senate, were unsuccessful.

Echoing Trump's critique of why they failed, Graham noted that "we were one vote short in the Senate" — an apparent reference to his late best friend and fellow Republican senator, John McCain. Trump continues to disparage McCain (Ariz.) for his thumbs-down vote on a skinny-repeal bill in 2017 that killed momentum for Republicans trying to do away with the Obama legacy law as they had been promising to do for seven years.

"We've got to remind people that we're not for Obamacare," Graham said in the radio interview.

"If we can get the House back and keep our majority in the Senate, and President Trump wins reelection, I can promise you not only are we going to repeal Obamacare, we're going to do it in a smart way where South Carolina will be the biggest winner," Graham said.

Democrats credit health care with their electoral successes in 2018. They ran on the GOP's desire to dismantle the ACA, specifically the lack of a plan to protect coverage for people with preexisting conditions. The issue remains relevant going into the 2020 elections, as a lawsuit to overturn the entire law makes its way through the courts with support from the Trump administration.

"Republicans are STILL trying to take away protections for people with pre-existing conditions and kick tens of millions off their health coverage," Senate Minority Leader Charles E. Schumer (D-N.Y.) tweeted in response to Graham's comments.

A few hours later, House Speaker Nancy Pelosi (D-Calif.) also reacted.

"The Affordable Care Act remains the law because Democrats have fought back Republican attack and sabotage," Pelosi tweeted.

Graham wrote his own version of an ACA repeal bill in 2017 that would have shifted decision-making on coverage plans to states, notably by allowing them to decide not to cover any of the essential benefits, which the ACA requires, such as mental health care and addiction treatment.

Trump and other Republicans, in the wake of the two mass shootings in Texas and Ohio over the weekend, have spoken about their desire to do something on mental health, but GOP policies on health care have run counter to that.

In the radio interview, Graham also seemed to slip up when he credited the strong economy to President Barack Obama instead of Trump.

“It’s no accident that under President Obama the economy is humming; there‘s more jobs and more money in your paycheck,” Graham said.

In the background, someone can be heard saying, “What?”

New rules to deny green cards to many legal immigrants
Colleen Long and Jill Colvin

WASHINGTON (AP) — The Trump administration announced Monday it is moving forward with one of its most aggressive steps yet to restrict legal immigration: Denying green cards to many migrants who use Medicaid, food stamps, housing vouchers or other forms of public assistance.

Federal law already requires those seeking to become permanent residents or gain legal status to prove they will not be a burden to the U.S. — a “public charge,” in government speak —but the new rules detail a broader range of programs that could disqualify them.

It’s part of a dramatic overhaul of the nation’s immigration system that the administration has been working to put in place, despite legal pushback. While most attention has focused on President Donald Trump’s efforts to crack down on illegal immigration, including recent raids in Mississippi and the continued separation of migrant parents from their children, the new rules target people who entered the United States legally and are seeking permanent status.

Trump is trying to move the U.S. toward a system that focuses on immigrants’ skills instead of emphasizing the reunification of families.

Under the new rules, U.S. Citizenship and Immigration Services will now weigh whether applicants have received public assistance along with other factors such as education, income and health to determine whether to grant legal status.

The rules will take effect in mid-October. They don't apply to U.S. citizens, though immigrants related to the citizens may be subject to them.

Ken Cuccinelli, acting director of Citizenship and Immigration Services, said the rule change will ensure those who come to the country don't become a burden, though they pay taxes.

"We want to see people coming to this country who are self-sufficient," Cuccinelli said. "That's a core principle of the American dream. It's deeply embedded in our history, and particularly our history related to legal immigration."

Migrants make up a small percentage of those who get public benefits. In fact, many are ineligible for such benefits because of their immigration status.

Immigrant rights groups strongly criticized the changes, warning the rules would scare immigrants away from asking for needed help. And they voiced concern the rules give officials too much authority to decide whether someone is likely to need public assistance in the future.

The Los Angeles-based National Immigration Law Center said it would file a lawsuit, calling the new rules an attempt to redefine the legal immigration system "in order to disenfranchise communities of color and favor the wealthy."

And David Skorton, president and CEO of the Association of American Medical Colleges said, "The consequences of this action will be to potentially exacerbate illnesses and increase the costs of care when their condition becomes too severe to ignore,"

"This change will worsen existing health inequities and disparities, cause further harm to many underserved and vulnerable populations and increase costs to the health care system overall, which will affect all patients," he said in a statement.

Cuccinelli defended the move, insisting the administration was not rejecting long-held American values.

Pressed on the Emma Lazarus poem emblazoned below the Statue of Liberty that reads: "Give me your tired, your poor, your huddled masses yearning to breathe free," he told reporters at the White House: "I'm certainly not prepared to take anything down off the Statue of Liberty."

A new Pew Research Center survey released Monday found the American public is broadly critical of the administration's handling of the wave of migrants at the southern

border, with nearly two-thirds of Americans — 65% — saying the federal government is doing a very bad or somewhat bad job. The survey found broad support for developing a pathway to legal status for immigrants living in the country illegally.

On average, 544,000 people apply for green cards every year, with about 382,000 falling into categories that would be subject to the new review, according to the government. Guidelines in use since 1999 refer to a “public charge” as someone primarily dependent on cash assistance, income maintenance or government support.

Under the new rules, the Department of Homeland Security has redefined a public charge as someone who is “more likely than not” to receive public benefits for more than 12 months within a 36-month period. If someone uses two benefits, that is counted as two months. And the definition has been broadened to include Medicaid, housing assistance and food assistance under the Supplemental Nutrition Assistance Program, or SNAP.

Following publication of the proposed rules last fall, the Homeland Security Department received 266,000 public comments, more than triple the average number. It made a series of amendments to the final rules as a result.

For example, women who are pregnant and on Medicaid or who need public assistance will not be subject to the new rules during pregnancy or for 60 days after giving birth. The Medicare Part D low-income subsidy also won’t be considered a public benefit. And benefits received by children until the age of 21 won’t be considered. Nor will emergency medical assistance, school lunch programs, foster care or adoption, student loans and mortgages, food pantries, homeless shelters or disaster relief.

Active U.S. military members are also exempt, as are refugees and asylum seekers. And the rules will not be applied retroactively, officials said.

Green card hopefuls will be required to submit three years of federal tax returns in addition to a history of employment. If immigrants have private health insurance, that will weigh heavily in their favor.

According to an Associated Press analysis of census data, low-income immigrants who are not citizens use Medicaid, food aid, cash assistance and Supplemental Security Income, or SSI, at a lower rate than comparable low-income native-born adults.

Non-citizen immigrants represent 6.5% of those participating in Medicaid and 8.8% of those receiving food assistance.

The new public assistance threshold, taken together with higher requirements for education, work skills and health, will make it more difficult for immigrants to qualify for green cards, advocates say.

“Without a single change in the law by Congress, the Trump public charge rules mean many more U.S. citizens are being and will be denied the opportunity to live together in

the U.S. with their spouses, children and parents," said Ur Jaddou, a former Citizenship and Immigration Services chief counsel who is now director of the DHS Watch run by an immigrant advocacy group. "These are not just small changes. They are big changes with enormous consequences for U.S. citizens."

Data shows drop in coverage among people ineligible for ObamaCare subsidies
Peter Sullivan

Health insurance enrollment declined among people who do not qualify for financial help under ObamaCare as premiums rose to make coverage less affordable, new federal data shows.

The data released by the Centers for Medicare and Medicaid Services (CMS) on Monday shows that enrollment declined by 1.2 million people, or 24 percent, between 2017 and 2018 among people with incomes too high to qualify for ObamaCare subsidies.

In contrast, in the same period, enrollment ticked up by 300,000 people among those with lower incomes who did qualify for financial help under ObamaCare.
The data illustrates that while ObamaCare remains stable given the subsidies available to lower-income people, premium increases helped drive away people with higher incomes, experts said.

"As premiums have risen recently, middle-class people have taken it on the chin," Larry Levitt, a health policy expert at the Kaiser Family Foundation, wrote on Twitter.
Premiums increased by 26 percent between 2017 and 2018, the report found.

Among people who do qualify for ObamaCare subsidies, those making below about $100,000 for a family of four, the picture is far more stable.

The data shows 10.6 million people had coverage on the ObamaCare exchanges as of February 2019, about the same number as the year before.

And after years of steep increases, average ObamaCare premiums actually declined by 1 percent between 2018 and 2019, as many insurers stopped losing money in the market.

The Trump administration pointed to the enrollment declines among people not getting subsidies to argue ObamaCare is failing.

“As President Trump predicted, people are fleeing the individual market,” said CMS Administrator Seema Verma. “Obamacare is failing the American people, and the ongoing exodus of the unsubsidized population from the market proves that Obamacare’s sky-high premiums are unaffordable.”

Cynthia Cox, another Kaiser Family Foundation expert, pointed out that the individual market for health insurance, including both those who receive and do not receive ObamaCare subsidies, is still larger than it was before the Affordable Care Act (ACA).

“There are about 10.6 million people signed up ON the exchange markets in early 2019,” she wrote on Twitter. “Plus, there are a few more million people signed up OFF-exchange.”

“Pre-ACA, the entire individual market was about 10.5 million people,” she added.

AXIOS

Wealthier people are ditching the ACA exchanges
Sam Baker

The universe of people covered by the Affordable Care Act keeps narrowing.

Between the lines: People who make too much money to qualify for help paying their premiums are fleeing the ACA’s insurance exchanges. But the exchanges are still pretty stable for people who receive premium subsidies, according to new federal data.

You can see two clear trends in these data.

- First, unsubsidized enrollment has fallen as premiums continue to rise. That makes sense: If you’re on the hook for your entire premium, you’re more likely to bail when those premiums rise.
- Overall enrollment tapered off under the Trump administration, which also makes sense: Trump’s policy decisions contributed to big premium spikes in 2018, and he has also expanded access to non-ACA options that may be more attractive to healthier, unsubsidized people.
- My thought bubble: This is the continuation of a somewhat ironic trend. As the ACA’s coverage expansion has shrunk, the law has evolved to look more like a traditionally liberal health care program.

- Part of the initial goal was to create a competitive marketplace that would benefit even the middle-class households too wealthy for a premium subsidy.
- That's the part that has fallen by the wayside as the ACA's coverage expansion has narrowed down. Now it's mainly direct government assistance — through Medicaid and premium subsidies — that's concentrated among the poorest households.

Trump health chief: Officials actively 'working on' ObamaCare replacement plan
Peter Sullivan

A top Trump health administrator on Thursday said that officials are actively "working on" a plan to repeal and replace ObamaCare, which has remained a priority for President Trump even as many congressional Republicans look to move on.

Trump has long promised a superior plan to replace ObamaCare and has drawn pushback from Democrats for never actually revealing a plan of his own.

Trump said in an ABC interview in June of a replacement plan, "We'll be announcing that in two months, maybe less."
Centers for Medicare and Medicaid Services Administrator Seema Verma declined to give a timeline for the release of the plan when speaking to reporters on Thursday.

But she said that administration officials are working on it.

"Yes, we're actively engaged in conversations and working on things," Verma said.

Earlier this month, Trump adviser Kellyanne Conway indicated that a health care announcement could be coming in September, though she did not provide any details of what would be in it or how specific it would be.

Officials have also emphasized other actions as making up parts of the administration's health care plan, like moves on drug prices and increasing transparency in health care pricing.

Trump has acknowledged that congressional action on repealing and replacing ObamaCare would have to wait until after the 2020 elections, given that Democrats currently control the House.

But the continued push from the administration highlights the stakes of the election, given that Trump says that if Republicans keep the White House and Senate and regain the House, he would renew his push to repeal and replace the law.

The Trump administration is also supporting a lawsuit currently making its way through the courts that seeks to overturn the entire law.

Many congressional Republicans wish that Trump would move on, given the success Democrats had last year in running on maintaining provisions in the law like protections for people with pre-existing conditions.

California leads latest lawsuit over Trump immigration rule
Don Thompson

SACRAMENTO, Calif. (AP) — California and three other states on Friday filed the latest court challenge to new Trump administration rules blocking green cards for many immigrants who use public assistance including Medicaid, food stamps and housing vouchers.

Nearly half of Americans would be considered a burden if the same standards were applied to U.S. citizens, said California Attorney General Xavier Becerra.

“This Trump rule weaponizes nutrition, health care and housing,” Becerra said, by potentially blocking legal immigrants from becoming citizens “if your child participates in something as basic as your neighborhood school lunch or nutrition program.”

The lawsuit he filed in U.S. District Court in San Francisco follows others this week including those by Washington and 12 other states and by two California counties. Joining California are Maine, Oregon and Pennsylvania, as well as the District of Columbia.

Thirteen immigrant advocacy and legal groups led by La Clínica de la Raza filed a separate lawsuit Friday in the same court, arguing the regulation was motivated by racial bias.

The lawsuits all contest one of Republican President Donald Trump’s most aggressive moves to restrict legal immigration. A spokesman for the White House declined comment while U.S. Citizenship and Immigration Services did not respond to a request for comment.

The new rules set to take effect in October would broaden a range of programs that can disqualify immigrants from legal status if they are deemed to be a burden to the United States — what's known as a "public charge."

Becerra, a Democrat, said working families across the country rely on similar safety net programs. The impact is particularly great in California, which has more than 10 million immigrants. Half of the state's children have an immigrant parent, he said.

His lawsuit argues that the rule creates unnecessary new obstacles for immigrants who want to legally live in the United States. It also discourages them from using health, nutrition, housing and other programs for fear it will erode their chances of being granted lawful status.

"The whole point is to create anxiety and create that chilling effect," California's Democratic governor, Gavin Newsom, said at a news conference with Becerra, immigration advocates and services providers. "You already are seeing a decline in people that are getting supports that they're legally entitled to."

Newsom said Trump "has a particular problem with brown people — not even immigrants."

He later said he was "not going there" by following other Democrats who have called Trump a white supremacist, "but he says a lot of things that make a lot of people that do identify with that term very happy. The continued assault on the Hispanic community, it's not even any question; it's just self-evident."

Newsom pointed to the rule change as well as recent immigration raids in Mississippi and a mass shooting by a man who authorities believe targeted Mexicans at a Walmart store in the Texas border city of El Paso.

"Connect some dots," Newsom said. "Why is it even an open question, what's going on this country and what's going on with this administration, and what they're trying to do and who they're trying to blame."

Becerra's mother was born in Mexico, coming to the U.S. after marrying his father, and he said she likely would have been affected by the policy. The rules don't apply to U.S. citizens, but he said they can discourage citizens from participating if they have an immigrant in their family.

Many immigrants are ineligible for public benefits because of their status, and an Associated Press analysis found low-income immigrants use Medicaid, food aid, cash assistance and Supplemental Security Income, or SSI, at a lower rate than comparable low-income native-born adults.

Trump's attempts to thwart illegal immigration have drawn the most attention, but the latest announcement Monday affects people who entered the United States legally and are seeking permanent status.

"We want to see people coming to this country who are self-sufficient," said Ken Cuccinelli, the acting director of Citizenship and Immigration Services.

KHN
KAISER HEALTH NEWS

Health Plan's 'Cadillac Tax' May Finally Be Running Out Of Gas
Julie Rovner

The politics of health care are changing. And one of the most controversial parts of the Affordable Care Act — the so-called Cadillac tax — may be about to change with it.

The Cadillac tax is a 40% tax on the most generous employer-provided health insurance plans — those that cost more than $11,200 for an individual policy or $30,150 for family coverage. It was supposed to take effect in 2018, but Congress has delayed it twice. And the House recently voted overwhelmingly — 419-6 — to repeal it entirely. A Senate companion bill has 61 co-sponsors — more than enough to ensure passage.

The tax was always an unpopular and controversial part of the 2010 health law because the expectation was that employers would cut benefits to avoid paying the tax. But ACA backers said it was necessary to help pay for the law's nearly $1 trillion cost and help stem the use of what was seen as potentially unnecessary care. In the ensuing years, however, public opinion has shifted decisively, as premiums and out-of-pocket costs have soared. Now the biggest health issue is not how much the nation is spending on health care, but how much individuals are.

"Voters deeply care about health care still," said Heather Meade, a spokeswoman for the Alliance to Fight the 40, a coalition of business, labor and patient advocacy groups urging repeal of the Cadillac tax. "But it is about their own personal cost and their ability to afford health care."

Stan Dorn, a senior fellow at Families USA, recently wrote in the journal Health Affairs that the backers of the ACA thought the tax was necessary to sell the law to people concerned about its price tag and to cut back on overly generous benefits that could drive up health costs. But transitions in health care, such as the increasing use of high-deductible plans, make that argument less compelling, he said.

"Nowadays, few observers would argue that [employer-sponsored insurance] gives most workers and their families excessive coverage," he wrote.

The possibility of the tax has been “casting a statutory shadow over 180 million Americans’ health plans, which we know, from HR administrators and employee reps in real life, has added pressure to shift coverage into higher-deductible plans, which falls on the backs of working Americans,” said Rep. Joe Courtney (D-Conn.).

Support or opposition to the Cadillac tax has never broken down cleanly along party lines. For example, economists from across the ideological spectrum supported its inclusion in the ACA, and many continue to endorse it.

“If people have insurance that pays for too much, they don’t have enough skin in the game. They may be too quick to seek professional medical care. They may too easily accede when physicians recommend superfluous tests and treatments,” wrote N. Gregory Mankiw, an economics adviser in the George W. Bush administration, and Lawrence Summers, an economic aide to President Barack Obama, in a 2015 column. “Such behavior can drive national health spending beyond what is necessary and desirable.”

At the same time, however, the tax has been bitterly opposed by organized labor, a key constituency for Democrats. “Many unions have been unable to bargain for higher wages, but they have been taking more generous health benefits instead for years,” said Robert Blendon, a professor at the Harvard T.H. Chan School of Public Health who studies health and public opinion.

Now, unions say, those benefits are disappearing, with premiums, deductibles and other cost sharing rising as employers scramble to stay under the threshold for the impending tax. “Employers are using the tax as justification to shift more costs to employees, raising costs for workers and their families,” said a letter to members of Congress from the Service Employees International Union.

Deductibles have been rising for a number of reasons, the possibility of the tax among them. According to a 2018 survey by the federal government’s National Center for Health Statistics, nearly half of Americans under age 65 (47%) had high-deductible health plans. Those are plans that have deductibles of at least $1,350 for individual coverage or $2,700 for family coverage.

It’s not yet clear if the Senate will take up the House-passed bill, or one like it.

The senators leading the charge in that chamber — Mike Rounds (R-S.D.) and Martin Heinrich (D-N.M.) — have already written to Senate Majority Leader Mitch McConnell to urge him to bring the bill to the floor following the House’s overwhelming vote.

“At a time when health care expenses continue to go up, and Congress remains divided on many issues, the repeal of the Cadillac Tax is something that has true bipartisan support,” the letter said.

Still, there is opposition. A letter to the Senate on July 29 from economists and other health experts argued that the tax “will help curtail the growth of private health

insurance premiums by encouraging employers to limit the costs of plans to the tax-free amount." The letter also pointed out that repealing the tax "would add directly to the federal budget deficit, an estimated $197 billion over the next decade, according to the Joint Committee on Taxation."

Still, if McConnell does bring the bill up, there is little doubt it would pass, despite support for the tax from economists and budget watchdogs.

"When employers and employees agree in lockstep that they hate it, there are not enough economists out there to outvote them," said former Senate GOP aide Rodney Whitlock, now a health care consultant.

Harvard professor Blendon agrees. "Voters are saying, 'We want you to lower our health costs,'" he said. The Cadillac tax, at least for those affected by it, would do the opposite.

Paging more doctors: California's worsening physician shortage
Elizabeth Aguilera

In a northern California valley stretching under miles of bright blue sky between two snowy volcanic peaks, Mt. Lassen and Mt. Shasta, Daniel Dahle is known as a godsend, a friend, a lifesaver, a companion until the end.

For more than three decades, "Doc" Dahle has been the physician in Bieber, serving a region about the size of five smaller U.S. states. When he started, he was one of five doctors in the region. Today he is joined by only one other full-time physician.

At 71, Dahle has delayed retirement for years — waiting for someone to take his place.

"I was going to retire November 8th of last year; it was going to be a third of a century," he said. "It's tough to recruit young new vibrant family practitioners or internists or pediatricians to come up here."

Unfortunately, Dahle's situation is not unique.

California is facing a growing shortage of primary care physicians, one that is already afflicting rural areas and low-income inner city areas, and is forecasted to impact millions of people within ten years. Not enough newly minted doctors are going into primary care, and a third of the doctors in the state are over 55 and looking to retire soon, according to a study by the Healthforce Center at UC-San Francisco.

That means by 2030, the state is going to be in dire need of physicians. Studies show the state could be down by as many as 10,000 primary care clinicians, including nurse practitioners and physician assistants. Some areas — the Central Valley, Central Coast and Southern Border region — will be hit especially hard. So too will be remote rural and inner-city residents, communities of color, the elderly, those with mental illness or addiction, and those without health coverage.

Many people will be forced to wait longer for doctor visits, travel longer distances to see someone, and may become so discouraged they forego preventative care and even care for chronic, serious disease until emergency treatment is necessary.

The federal government's Council on Graduate Medical Education recommends 60 to 80 primary care doctors per 100,000 people. Statewide in California, the number already is down to just 50 per 100,000 — and in some places it's even lower: down to 35 in the Inland Empire and 39 in the San Joaquin Valley, according to a report from The Future Health Workforce Commision.

Among the causes of the physician shortage:

High student loan debt induces medical students to go into specialty care, which pays more than primary care — currently only 36 percent of doctors provide primary care.
Low Medi-Cal reimbursement rates for primary care drive doctors away from low-income areas and primary care.
Even primary care physicians often shy away from rural areas, opting instead to practice in big cities near medical centers and specialists.
Medical school students don't reflect the diversity of the state, which also influences where new doctors practice — and where they don't.
UC Davis Medical School Dean of Admissions and Outreach Mark Henderson said his medical school is focused on trying to eliminate the shortage between Davis and the Oregon border.

At Davis, where there is a focus on primary and rural care, about half of graduates go into primary care. But at most other medical schools, that percentage is 20 to 30 percent and it's not enough.

"We still don't take enough students from (rural and underserved) communities that will have a deep desire to want to go back to the community," Henderson said. "You have to take a different type of a student, you can't take the same old usual suspect."

New doctors "take these specialty areas that pay higher, and that leaves us with a shortage of primary care physicians including pediatricians, internists, family practice physicians and OB/GYNs," said John Baackes, CEO of LA Care Health Plan, which has the largest number of Medi-Cal members in the state.

He said in rural areas, veteran doctors who are solo practitioners are having a hard time bringing in new doctors to take over.

“Young doctors are increasingly going to salaried positions” at institutions such as Kaiser, said Baackes.

In low-income areas, a different deterrent comes into play. Dismal Medi-Cal reimbursement rates keep some students out of primary care and repels some primary medical graduates, said Elaine Batchlor, CEO of MLK Jr. Community Hospital in South Los Angeles.

“It’s difficult for physicians to support a practice in that environment and organized medical groups are not attracted to the community because of low (Medi-Cal) reimbursements,” she said.

The California Future Health Workforce Commission — made up of business, elected and health care leaders — released a report earlier this year warning of the looming shortage of health workers to meet the needs of the “growing, aging and increasingly diverse population.”

“If we’re looking to the future in a state where we have everyone covered, we can’t do it with the workforce we have and we are not doing it well now in many places,” said Assemblyman Jim Wood, a Santa Rosa Democrat who was part of the commission.

The commission found that already 7 million Californians live in federally designated Health Professional Shortage Areas because they lack primary care physicians, dentists and mental health professionals. Most are in the Inland Empire, part of Los Angeles, the San Joaquin Valley and in remote parts of the state, like where Dahle practices.

He tries to assist the next generation of providers: He takes physician-assistant trainees nearly year-round from the University of Iowa, where one of his former physician assistants runs a program.

“These guys are smarter than me already,” Dahle said. “Actually, we teach each other. We teach them the art of medicine and they teach me all the new science of medicine. It works out really good.”

The trainees live with Dahle in his log cabin on 160 acres just outside of town, down a 5-mile dirt road. His dog Clint, a Pyrenees he rescued, eagerly awaits him each afternoon.

Over the course of two recent days, Dahle treated patients with hyperthyroidism, migraines, diabetes, swollen lymph nodes, chronic ear infections, knee pain and constant nausea, and performed a skin biopsy to test for cancer.

Inevitably, country doctors have to be able to do more with less — and be willing to live far from urbanity.

“The younger generation of providers, they don’t have the clinical skills or know-how. They’re not trained the same as Dr. Dahle,” said Shannon Gerig, CEO of Mountain Valleys Health Centers, which operates seven centers across 6,000 square miles in the northern part of California including in Bieber, where Dahle is the lone doctor at that center. “It’s a scary thing for them to come out and be so remote, and know that they are going to be solo a lot, and they are going to be depended on by the mid-level staff…and they don’t have specialty (doctors) around them.”

Dahle has birthed thousands of babies, diagnosed cancers, done skin biopsies, assisted in minor surgeries, attended to patients on their deathbeds and occasionally rushed out into the forest or to a ranch to treat those whacked by a falling hay bale, a downed tree or a stubborn horse. He once finished a pelvic exam by flashflight because the power went out, did minor toe surgery in his office while taking direction from a surgeon on the phone, and jumped in a helicopter transport to accompany a patient with a broken neck enroute to a far-away trauma center.

He also works in the Fall River Mills’ emergency room one 24-hour shift a week, and makes hospital rounds first thing most days.

One recent morning, he greeted and joked with Wilma Chesbro, 88, who used to be an operating room scrub nurse with Dahle, and now is a patient in long-term care.

She grasped his hand, reminding him that when they first met decades ago she thought he was a “yokel” because he’s from a local town. But Chesbroe cried and lost her breath every time she tried to express just how much Dahle meant to her.

“He’s brilliant,” she said through her tears. “But he doesn’t show it. I have so much respect for him.”

Earlier this year he was named Country Doctor of the Year by AMN Healthcare, the largest health staffing agency in the country. The welcome sign to Bieber announces it has 510 residents; the health centers there cater to about 17,000 residents across several towns.

Much of the area is designated “frontier” by the federal government because so few people live there. Beiber has one motel, and passersby who blink might miss the Big Valley Market, where Dahle gets a maple bar for breakfast most days. Fields and ranches dot the wide-open valley, giving way to forests and rising peaks. The nearest Safeway grocery store is in Burney, 40 miles away. The isolation has made some prospective physicians make a U-turn and drive away, without ever stepping foot in the clinic for their scheduled interview. Many have told Dahle their spouse or partner saw the town and said “no way.”

Doc Dahle grew up in nearby Tulelake, the son of a potato farmer. He was drafted from college to Vietnam. Later he finished college at Oregon State, then was turned down for medical school there four times before he was accepted at the University of Rochester.

When he graduated he returned to northern California to practice. His cousin is Brian Dahle, a GOP state senator who represents the area.

But Doc Dahle may just be the better known of the two. Thousands of residents in these parts go out of their way to see him.

“Patients are fine waiting, because they know when they see Dr. Dahle he will take whatever amount of time he needs to talk with them, to get the care they need. I guess you’d call it old school,” said Gerig, who was Dahle’s patient before becoming his boss.

She began working as a registered nurse with Dahle 25 years ago, and he delivered her three babies via C-section. It seems everyone has a connection like that. At a local bar, a group of guys ticked off what Dahle has done for them — one called him a “lifesaver” for diagnosing a 99 percent carotid artery blockage.

This is why Dahle is fired up about finding his replacement. This is his “family,” he said.

He’s got his eye on a young doctor couple out of Davis. But there is one hitch. The local hospital in Fall River Mills, just about 25 miles up the road, closed its obstetrics unit, forcing pregnant women go at least a hundred miles to Redding or Shasta to deliver.

Unless the hospital reopens that wing, Dahle may not be able to land the couple despite their interest. The husband is in primary care and has already filled in at Dahle’s clinic, but the wife, who is from Fall River Mills, is training to be an OB-GYN.

“We’re not going to be able to recruit these homegrown kids to come back here without something changing,” said Dahle. “We have got to do this for our community.”

That’s the reason he’s sticking around, for the community and to work on bringing the couple back home.

“I love my job,” said Dahle, who is twice divorced, acknowledging it was always hard to stay married because he is wedded to medicine. “I have never regretted ever being a doctor. Everyday I go to work and say that I help somebody.”

If he ever does retire, he plans to to scuba dive, hunt rocks and travel.

But he’ll still probably have lunch on Tuesdays at the Roundup Bar, just like he does now for the hot dog special. Sometimes, if someone sees Dahle heading over, they’ll call the bar and buy Dahle’s beer.

“He’s a staple in our community. He holds us all together,” said bar owner Scott Johnson.“This is like his second office. He comes here and everyone gathers round and asks him questions to avoid a doctor visit.”

USA TODAY

Signs of trouble - and progress - as Obamacare 2019 open enrollment nears
Jayne O'Donnell

In a northern California valley stretching under miles of bright blue sky between two snowy volcanic peaks, Mt. Lassen and Mt. Shasta, Daniel Dahle is known as a godsend, a friend, a lifesaver, a companion until the end.

For more than three decades, "Doc" Dahle has been the physician in Bieber, serving a region about the size of five smaller U.S. states. When he started, he was one of five doctors in the region. Today he is joined by only one other full-time physician.

The latest health insurance data gives new ammunition to the Trump administration as it touts the latest bad news on Obamacare, but supporters of the law say there are positive signs for the state and federal marketplaces as 2019 open enrollment nears.

A study out Thursday showed the number of uninsured people increased in 2017 for the first time since the Affordable Care Act exchanges opened in 2013. Last week, the Centers for Medicare and Medicaid Services reported 2.5 million people left the Obamacare health insurance exchanges between 2016 and 2018.

There's as much disagreement over why and whether things are worse as there was over the health law.

Health and Human Services Secretary Alex Azar tweeted that the 40% drop in people covered by insurance represents half what the Obama administration promised when the law passed.

This group that left the state and federal marketplaces doesn't get federal tax credits to pay for their plans. Under the ACA, only people who make less than 400% of the federal poverty limit (or $103,000 for a family of four) are eligible for financial help.

The administration has also tried to repeal all and parts of the law, which ACA backers say has undermined the law, but some see bright spots in the more recent data.

Others say there's plenty of blame to go around.

For those who don't get federal help to pay their premiums, "there is nothing in the ACA that makes insurance affordable and nothing that has been passed that has or will bring down the cost of health insurance," says Ronnell Nolan, a Baton Rouge, La. insurance

broker and president of the trade group Health Agents for America. "Health care and the cost of drugs continue to skyrocket."

Several factors, led by high premiums, slowed health insurance enrollment by people who aren't getting their coverage subsidized by the government. Insurers that continued to sell on the exchanges after the first couple of years raised rates to adjust for sicker patients and these rates only soared higher after the administration refused to continue reimbursing insurers for their share of subsidies to reduce patients' out of pocket costs.

Chief among them are all the other health insurance options that are now both available and allowable. Starting in 2020, They also include court battles over administration proposals including to allow employers to band together in what's known as "association" health plans, the availability of group plans for as few as two people in some states and the elimination of the tax penalty for remaining uninsured.

"The result is that middle class people felt the full brunt and in many cases dropped out entirely," says Larry Levitt, executive vice president at the non-profit Kaiser Family Foundation.

In some states, insurers can and will sell a group policy to even a married couple, said Nolan, although they have to work together. Tracy McMillan, who owns the Arlington, Texas-based Marketplace Insurance Exchange Group, says she has clients in very small group plans who wind up paying about half of what they'd pay if they bought unsubsidized plans on HealthCare.gov.

Some insurance companies maintain these plans violate the Employee Retirement income Security Act and agents including Gail Hiller-Lee in Uniondale, NY have been pushing state and federal regulators to make them more widely available because of the premiums self-employed people ineligible for subsidies are facing.

"We try to get them the cheapest price and group plans are cheaper than individual," says Nolan.

Katherine Hempstead, a senior policy adviser at the Robert Wood Johnson Foundation, says there have been "signs of improvement" this year, including with enrollment by people who don't receive financial help to buy their insurance.

Cathryn Donaldson, spokeswoman for the trade group America's Health Insurance Plans, notes that every county had at least one option for individuals seeking insurance coverage. Premium increases were also generally lower, and decreased in some markets with increased competition.

Consumers in some rural states are starting to see more options and lower prices. Several states that have struggled with a lack of competition - Nebraska, Mississippi, Oklahoma, Utah, South Carolina, Wyoming and Iowa -- all showed healthy increases in enrollment among people below 400% of the federal poverty limit, according to CMS' new data.

Several insurance companies, including Bright Health, Oscar, Centene, Cigna, and Anthem, have expanded where they are selling after years of declines in overall insurance participation on the exchanges, says Hempstead. For 2020, Hempstead says she expects premium increases to be below average and more insurers to enter the marketplaces than leave. The number of counties with only one choice has been declining since 2018.

Problems remain, however. Along with paying for insurance, they include:

•Cost of care. Even the lowest income consumers who pay almost nothing out of pocket for their coverage, face considerable hurdles paying for their share of the actual care. McMillan hosts fundraisers to raise money for her low-income clients who need to use their cheap or even free insurance in emergencies yet can't afford to.

Debra and Jim Fallon of Dalworthington Gardens, Texas pay for the cheapest plan they could find for Debra on the federal health care exchange – and it costs nearly $1,000 a month, has a $6,000 deductible and few of her doctors take it.
Debra and Jim Fallon of Dalworthington Gardens, Texas pay for the cheapest plan they could find for Debra on the federal health care exchange – and it costs nearly $1,000 a month, has a $6,000 deductible and few of her doctors take it. (Photo: Fallon family photo)

•Spotty networks. Agents say many patients have trouble finding doctors who will accept the insurance they can afford. Debra Fallon and her husband Jim are paying nearly $1,000 a month with a $6,000 deductible for the least expensive plan they could find for Debra - and it doesn't even include most of her doctors. Jim is on Medicare. The couple live in Dalworthington Gardens, Texas, where Debra's Crohn's Disease made it necessary for her to use the state's high-risk pool to get her coverage before the ACA. The premium and deductible - $562 a month with a $1,000 deductible - was high at the time, but is now something they miss.

While the Fallons would be fine with the pre-ACA days, Ashley Candler of Austin credits the law with "saving her life."

She had thousands of dollars in medical debt when the ACA passed and had no insurance after a divorce. Now she doesn't have to pay anything for a premiums and just has to meet an $1,800 deductible. Candler says she suffers from post-traumatic stress disorder, bipolar disorder and attention deficit hyperactivity disorder. With insurance, she could get professional help for her mental health and in-patient treatment for addictions.

"Having the Affordable Care act made going to a regular doctor appointment less stressful due to not having to pay an arm and a leg to see a doctor," said Candler.

Forbes

The Best And Worst States For Healthcare in 2019
Jeanne Croteau

People want access to quality, affordable healthcare. That's why the average American spends more than $10,000 each year on health-related expenses. Yet, while we've seen improvements since implementing the Affordable Care Act, the United States is still lagging behind other wealthy nations in key areas such as life expectancy, quality of life and insurance coverage.

On top of that, where you live in the country will greatly impact the service you'll get from a healthcare provider. A recent study by WalletHub measured cost, accessibility and outcomes such as infant mortality and heart disease rates to determine which states are providing the best and worst healthcare to residents. Here's what they discovered.

Top 5 Best States for Healthcare in 2019

Minnesota
Massachusetts
Rhode Island
District of Columbia
Vermont

Top 5 Worst States for Healthcare in 2019

Alaska
North Carolina
Mississippi
South Carolina
Arkansas

Breaking down the results further yields additional insight into the problem. Let's look at Idaho, for example. Despite having the second-lowest average monthly insurance premium costs in the country, it's tied for third-highest percentage of at-risk adults not seeing a doctor in the last two years.

If the costs are low, why aren't more people seeing doctors when they need to? The data shows that Idaho has the fewest physicians and the second-fewest hospital beds and dentists of all states per capita. The problem here in Idaho (the state where I happen to live right now), therefore, is a severe lack of access.

How Do We Fix The Healthcare Problem?

So, what's the solution? It's tricky because healthcare is such a hot topic in this country and having a conversation that leads to anything is almost impossible. Having moved to Idaho almost three years ago, we struggled to find reasonable, accessible healthcare options for our family. We were grateful when Appleton Clinics opened, because their direct primary care model is affordable and prioritizes patients over insurance companies. Not everyone has this option available to them, though.

Perhaps, that's why we're seeing a rise in telehealth, too. To beat the long waits and co-pays associated with seeing specialists, people are turning to virtual resources such as the First Derm Online Dermatology app. While these may be convenient for small issues, using them in place of a physical exam can be dangerous. It's hard to ensure the quality of an app-based medical consultation, which could lead to misdiagnosis or inadequate treatment plans.

It's heartbreaking to think that a newborn's chances of survival in Mississippi are lower than if they had been born in Massachusetts. It's devastating to imagine an individual living with chronic illness who faces an uphill battle to find a provider simply because their state is lacking access to these potentially life-saving services.

Knowledge is power, and while talking about these issues might be uncomfortable, informed discussions can help ensure that every American has access to the healthcare resources they need and deserve.

Column: The 10 worst things Trump has done to harm your healthcare
Michael Hiltzik

On Monday, Planned Parenthood announced that it was withdrawing from the government's Title X program, which provides healthcare services to low-income women, because the Trump administration had saddled Title X with a "gag rule" interfering with doctors' relationships with their patients.

The step means turning down $60 million in federal funding — the first time Planned Parenthood would go without Title X funds in the government program's nearly half-century existence. The Trump administration denies that the rule is a "gag rule," but that's hard to square with its explicit provisions. The rule prohibits recipients of the funding from referring patients to abortion providers; if they give patients a list of doctors for follow-up treatments, they "cannot indicate those on the list who provide abortion."

Planned Parenthood serves about 1.5 million low-income women under Title X, some of whom live in areas with few or no alternative healthcare providers for women. But the gag rule is merely one of many Trump administration actions and policies that have affected people's health for the worst. It can be hard to keep all of these initiatives straight or even to remember them all, so we've compiled a list of the top 10 — more precisely, the bottom 10 — so the cumulative impact is clearer.

This isn't an exhaustive list, merely a judgment call of the worst 10. It doesn't include measures aimed at ending anti-discrimination protections for LGBTQ patients, for instance, which are part of a broader attack on LGBTQ rights.

Because it's the most recent, we'll designate the gag rule as No. 1.

No. 2: Asking a court to declare the Affordable Care Act unconstitutional. In June 2018, the administration asserted in federal court that key provisions of the law are unconstitutional and refused to defend it against a legal challenge brought by 20 red states.

By throwing its weight behind a legal attack on the ACA that many legal experts consider frivolous and obtuse, Trump raised the stakes in the federal lawsuit brought by Texas and other red states. Its action placed at risk the healthcare of 133 million Americans dependent on the ACA's individual exchange health plans or its provisions for Medicaid expansion. The case is currently under consideration by a federal appeals court.

No. 3: The "public charge" rule. This recently finalized rule requires immigration officials to reject applications from immigrants to enter or stay in the U.S. if they have received — or are judged likely to require — any of several public benefits that are tied to need. These include public health services such as Medicaid. The predictable consequence is to discourage immigrant households from accessing such programs even when they're legally entitled.

As we reported in August 2018, when rumors of the impending rule began circulating, healthcare providers with immigrant clienteles already were seeing a reduction in patients. The director of a clinic in the Latino community of Boyle Heights in Los Angeles told me then that her monthly patient enrollments had fallen by 25% after the public-charge proposal leaked out — on top of a one-third drop after Trump's election.

Leaving aside the basic cruelty and inhumanity of a rule that instills fear in families, less healthcare for immigrants means a decline in the health profile of the entire community, raising costs for public programs and employers, among many others.

No. 4: Pulling the plug on teen pregnancy prevention. The writing was on the wall when Trump stocked the Department of Health and Human Services with advocates of abstinence-only sex education and birth control. The result became clear in June and July 2017, when 81 teen pregnancy programs around the country were told that their grants would end within the following year; one program that funded educational

outreach by Children's Hospital Los Angeles, among other institutions, was cut off immediately — just as it was beginning the second year of a five-year plan.

In all, more than $200 million in annual funding was ended. The risk is that teen pregnancies, which had been in a long-term decline, would head higher again, especially in communities with shrinking access to education and contraception.

The cutoff was the handiwork of a cadre of anti-abortion activists placed into high offices at HHS. One has promoted the claim that abortion increases a woman's chance of breast cancer and of "serious mental health problems," which is unsupported by medical science. Another treated anti-pregnancy education as a matter of morals, not empirical data. "As public health experts and policymakers, we must normalize sexual delay more than we normalize teen sex, even with contraception," she said. But studies consistently show that what reduces teen pregnancies is increased use of contraceptives.

No. 5: Work rules for Medicaid. The administration has gone full speed ahead on allowing states to impose work rules on residents enrolling in Medicaid, the program aimed at bringing health coverage to the poor. That's happening despite clear evidence that the rules are catastrophic for the target population's health coverage and do nothing to increase employment or produce job opportunities.

What happens in states that impose these rules is that thousands of enrollees are thrown off Medicaid, even if they remain eligible. That's because the rules are hard to administer and seem almost purposefully designed to pare enrollments. That's been noticed by federal Judge James Boasberg of Washington, D.C., who has overturned programs in Kentucky and Arkansas. Nevertheless, the administration has pushed ahead with approvals for six more states, all part of a concerted assault on Medicaid.

No. 6: Promoting short-term health plans. Almost from the inception of his administration, Trump has been clearing the way for the spread of short-term health plans. These are insurance plans that don't meet ACA standards. They don't cover all the services required by the ACA for qualifying plans, including pregnancy, mental health services and hospitalization. They reject applicants with preexisting conditions. They can impose lifetime benefit caps and weird restrictions such as refusals to cover hospitalizations that begin on a Friday or Saturday.

These plans are cheap because they're junk. Customers often aren't aware of their limitations until they try to access benefits. The Obama administration limited them to three-month nonrenewable terms, and some states, including California, have outlawed them entirely. Trump wants to allow them to last a year and be renewable, even though that could siphon healthier customers out of the ACA market, driving up premiums for everyone else — just one more device to sabotage the ACA.

No. 7: Appointing the worst healthcare officials. Trump began his tenure by naming former Rep. Tom Price (R-Ga.), a sworn enemy of the Affordable Care Act, to head HHS, the agency responsible for enforcing the law. Price immediately started

undercutting the law. Price cut the open enrollment period for plans sold through the federal exchanges, HealthCare.gov, from three months to six weeks, then cut the budget for marketing an outreach — which was needed to inform enrollees of the change — by 90%, claiming through department flacks that previous experience suggested that outreach had "diminishing returns," an assertion contradicted by hard evidence.

Price was ousted in October 2017 for ethical lapses, but just before leaving office, he ordered the health agency's 10 regional directors not to participate in state-based open enrollment events, an unprecedented withdrawal of federal support. Administration sabotage of the individual insurance market during his term was tied to more than half of the average 36% premium increases sought by insurers in 20 states analyzed by Charles Gaba of ACASignups.net.

Price was succeeded by Alex Azar, a former drug company executive and lobbyist who has silently presided over a continuation of Price's sabotage tactics. He remained mum when Trump filed papers asking the courts to declare the ACA unconstitutional, though he let it be known through pseudonymous friends that he opposed the action. (Why not go public?)

The quintessential Azar episode occurred in March, when he even acknowledged to a House committee that he had no evidence that work requirements did any good. In fact, he admitted that his department didn't even know why 20,000 Arkansans got thrown out of Medicaid. Nor could he produce a single study validating the assertion that imposing work requirements on Medicaid recipients made them healthier or helped them find jobs.

"You propose implementing mandatory work requirements for Medicaid beneficiaries not knowing what the impact will be, across every single state. What's the logic in that?" Azar was asked by Rep. Joseph P. Kennedy III (D-Mass.). Azar didn't have a cogent answer.

No. 8: Deliberately raising ACA premiums for 7.3 million people. In April, the administration issued a final rule for marketplace plans in 2020 that it acknowledged would raise premiums for 7.3 million consumers by cutting their premium subsidies. The administration conceded that the higher premiums would cause 70,000 people to drop marketplace coverage each year. The Center on Budget and Policy Priorities calculated that the change would cost a family of four with income of $80,000 an additional $208 annually.

The CBPP observed that the change was not required by the ACA or any other law. "The administration is making an entirely discretionary choice to raise costs for millions of people, just weeks after President Trump justified his latest efforts to repeal the ACA by arguing that it has resulted in premiums and deductibles that are too high." In its explanation of the rule, the administration said it would move forward even though, in its own words, "all commenters on this topic expressed opposition to or concerns about the proposed change."

No. 9: Eliminating the penalty for violating the ACA's individual mandate. The bill cutting taxes for corporations and the wealthy that Trump signed in December 2017 included a provision reducing to zero the penalty for violating the ACA's mandate that everyone carry insurance. The penalty was designed to prompt more young and healthy Americans to carry health insurance, which would keep premiums down for the general population.

The zeroing-out had an immediate effect on enrollment. California alone saw a 24% drop in new enrollments for 2019, the first year of the change (by more than 92,000 enrollees), almost entirely because of the penalty's elimination. "Even robust marketing cannot offset the negative impact of its removal," the exchange said.

No. 10: Allowing more employers to deny their workers coverage for contraception. In November 2018, the administration made final a rule vastly expanding the number of employers who could refuse to offer contraceptive coverage to their workers.

"The regulations open the door for any employer or college/university with a student health plan with objections to contraceptive coverage based on religious beliefs to qualify for an exemption, the Kaiser Family Foundation reported. "Any employer, except publicly traded corporations, with moral objections to contraception also qualify for an exemption. Their female employees, dependents, and students will no longer be entitled to coverage for the full range of FDA approved contraceptives at no cost."

The regulatory change was just one of many assaults on women's reproductive health.

MarketWatch

Obamacare is closing the coverage gap between rich and poor, black and white
Andrew Keshner

Five years after the Affordable Care Act took effect, the health-insurance overhaul has narrowed coverage gaps between the rich and poor, according to new research.

The health-care law erased 44% of the coverage gap between many poor Americans without health insurance and the few rich Americans without it, according to a study the National Bureau of Economic Research distributed on Monday. The law's provisions, especially its broadening of Medicaid programs, closed coverage gap between whites and minorities by 27%.

Coverage disparities shrank by 45% between married and non-married Americans and by 44% across age groups, according to U.S. Census Bureau data crunched by

researchers at University of Kentucky, the University of Pennsylvania and Georgia State University.

The Affordable Care Act (ACA), dubbed Obamacare, imposed health insurance market reforms, subsidized certain health plans and encouraged states to adopt broadened Medicaid programs for low-income residents beginning in 2014.

The law took effect after heated debate and a lawsuit that travelled all the way to the Supreme Court and ended with a 5-4 vote upholding the law. The researchers said their findings would be “extremely valuable” for the ongoing debate.

Don’t miss: This seemingly innocuous life event can double your risk of filing for bankruptcy

About 20 million people gained coverage in the wake the law and 37 states have adopted the expanded Medicaid program, said the Kaiser Family Foundation, an organization studying health care policy, which said Obamacare has achieved “historic gains.”

Skeptics say the Obamacare plans are poor quality, too expensive and the wrong way to use government money to address America’s health care problems. The study acknowledges ACA’s murky outlook, despite the gains. Last year, a Texas federal judge ruled the ACA was unconstitutional.

The ACA imposes a tax penalty for people who lack insurance. However, Republican lawmakers included provisions in a 2017 tax-code overhaul saying people without insurance didn’t have to pay money if they lacked coverage.

In response, U.S. District Judge Reed O’Connor said the law could not stand without the penalty. The case is being appealed, but the Trump administration says the judge’s decision should be affirmed. The case is now before the Fifth Circuit Court of Appeals; the lawsuit is destined for the Supreme Court as early as next year, observers say.

KFF
HENRY J KAISER FAMILY FOUNDATION

Data Note: Changes in Enrollment in the Individual Health Insurance Market through Early 2019
Rachel Fehr, Cynthia Cox and Larry Levitt

DATA NOTE ENDNOTES
The individual health insurance market – where people go to buy their own coverage both through the exchange Marketplaces and off-exchange directly from insurers or brokers – grew rapidly following implementation of the Affordable Care Act’s (ACA)

subsidies and prohibition of discrimination based on pre-existing conditions. However, these enrollment gains were partially offset by subsequent declines, particularly among people not receiving subsidies amid steep premium increases. Most recently, the ACA's individual mandate penalty was effectively repealed going into 2019, raising questions over whether enrollment would continue to drop.

In this analysis, we use publicly-available federal enrollment data and administrative data insurers report to the National Association of Insurance Commissioners (as compiled by Mark Farrah Associates) to measure changes in enrollment in the individual market before and after the ACA's coverage expansions and market rules went into effect in 2014 through the first quarter of 2019. Key findings include:

Total individual market enrollment, measured on an average monthly basis, increased from 10.6 million in 2013 to a peak of 17.4 million in 2015, before declining to 13.8 million in 2018.

Much of this decline was concentrated in the off-exchange market, where enrollees are not eligible for federal premium subsidies and therefore were not cushioned from the significant premium increases in 2017 and 2018.
Enrollment has continued to fall somewhat in early 2019, though may show signs of stabilizing, so long as premium growth continues to level off: First quarter enrollment has declined by 5% in 2019 compared to the first quarter of 2018.1 This is a smaller decline than had been seen in past years (11% in 2018 and 12% in 2017) amid steep premium increases.

As the ACA market rules and premium subsidies were implemented in 2014, there was significant growth in enrollment on the individual market. For the first time in nearly all states, people with pre-existing conditions could purchase coverage on an open marketplace and low-income people were eligible for tax credits to help pay their premiums and reductions in their cost sharing. In addition, many people who went without insurance coverage had to pay a tax penalty. As of 2014, health plans had to follow new rules that standardized benefits and guaranteed coverage for those with pre-existing conditions when selling coverage to new customers (known as "ACA-compliant" plans). Following these changes, individual market enrollment increased substantially, expanding from 10.6 million members on average per month in 2013 to 17.4 million members in 2015 (Figure 1)3. This included an estimated 3 million people in non-ACA compliant plans including some short-term plans, grandfathered plans, and plans purchased before October 2013 that were allowed to continue under a federal transition policy at the discretion of states and insurers.

In 2016, total individual market enrollment was relatively unchanged from the previous year (at 17.0 million), though there was a shift from non-compliant to ACA-compliant plans. Enrollment in the total individual market began to decline in 2017 and continued through 2018 (Figure 2). Both compliant and non-compliant enrollment declined, suggesting that people ending transitional, non-compliant policies were not necessarily moving to the ACA-compliant market. In 2018, enrollment in compliant plans decreased further to 12.5 million and enrollment in non-compliant plans decreased to 1.3 million.

Quarterly Changes in Individual Market Enrollment through Early 2019
First quarter enrollment data from 2019 show total individual enrollment continuing to decline somewhat as premiums leveled off, even as enrollment on the ACA exchanges has remained relatively stable (Figure 3). 13.7 million people are enrolled in the individual market as of the first quarter of 2019, 5% lower than the first quarter of 2018 – a drop of about 651 thousand people.

Exchange Coverage
Exchange enrollment, particularly subsidized exchange enrollment, has largely remained stable since 2015. In the first quarter of 2019, 10.6 million people were covered on the ACA exchanges, including 9.3 million people receiving federal premium subsidies4. Early 2019 exchange enrollment shows little change from the first quarter of 2018 when 10.6 million people were covered on-exchange, including 9.2 million receiving subsidies. As most people on the exchange receive subsidies that cap their premium payments at a certain share of their income, these enrollees are sheltered from the sticker price of premiums and would therefore be unlikely to drop their coverage due to changes in premiums.

Although exchange enrollment has held steady, according to CMS, the number of new consumers signing up for plans in 2019 dropped by 16% from 3.2 million to 2.7 million. This drop in new signups could be a result of a variety of factors, such as reductions in outreach and consumer assistance, repeal of the individual mandate penalty, or broader economic factors that may make people less likely to come into the market.

Off-Exchange Coverage
Declining off-exchange enrollment accounts for much of the drop in individual market enrollment since 2016. Total individual market enrollment began to decline in 2017 and has continued to fall through the first quarter of 2019 (Figure 4). Total individual market enrollment declined by 651 thousand people (5%) from the first quarter of 2018 to the first quarter of 2019. All of this decline was among unsubsidized enrollees, whose enrollment fell by 672 thousand (10%) from 2018 to 2019 (across unsubsidized ACA-compliant and non-compliant coverage).

Off-exchange enrollment includes ACA-compliant plans that are sold outside of the exchange but are part of the same risk pool as exchange plans, as well as non-compliant plans that do not meet ACA standards and have separate risk pools from the ACA-compliant plans. The primary distinction between on and off exchange ACA-compliant plans is that subsidies are only available through the exchange. To the extent that fewer healthy people buy off-exchange ACA-compliant plans, premiums in on-exchange plans are affected as well. Non-compliant plans (including grandfathered and some short-term plans) that are not part of the ACA risk pool are also included in off-exchange enrollment.

As unsubsidized enrollment has fallen over recent years, the individual market has increasingly become dominated by subsidized enrollees. In the first quarter of 2019, we

estimate over two thirds of enrollees in the individual market are receiving a premium subsidy (Figure 5).

LIMITATIONS OF Q1 NON-COMPLIANT COVERAGE ESTIMATES

In the first quarter of 2019, we estimate 2.1 million people were covered by off-exchange ACA-compliant plans, and 1.1 million people had non-compliant plans.5 A limitation of this analysis is that precise data on the number of people in non-compliant plans in early 2019 are not yet available. Additionally, while there are some data from the National Association of Insurance Commissioners on enrollment in short-term plans, these data are only available annually (so do not include 2019) and do not account for all short-term coverage, as some plans are sold through associations and would not necessarily be considered individual market coverage. In Figure 3 above, we estimate the share of off-exchange individual market enrollees who are in ACA-compliant and non-compliant plans in early 2019 by assuming the same share as in 2018. In past years, this method has proven to be reliable, however, 2019 may differ from past years because this is the first year in which the individual mandate penalty has effectively been repealed and more loosely regulated plans may have proliferated.

Annual filings provide a more complete picture of the individual market and allow for more precise estimates of compliant vs non-compliant enrollment. Quarterly filings provide a sense of how enrollment is changing on a more current basis. First quarter enrollment tends to be higher than average annual enrollment because the number of people who drop coverage throughout the year exceeds the number who purchase coverage through special enrollment periods outside of annual open enrollment.

Possible Reasons for Individual Market Enrollment Declines

There are a variety of possible explanations for these declines in individual market enrollment in recent years, including: rising premiums for ACA-compliant coverage; the expansion of loosely regulated plans that may not be considered individual market coverage yet could attract customers away from the individual market; the effective repeal of the individual mandate; and broader economic trends, like gains in employment, which could lead to more people having job-based coverage. While we know that individual market enrollment has declined in 2019, we do not yet know whether people leaving the individual market have gained coverage through other sources.

The most significant declines in individual market enrollment coincided with significant premium increases in 2017 and 2018. In the early years of the ACA exchanges, insurers underestimated how sick the new risk pool would be and set premiums too low to cover their claims. A number of insurers then exited the market and the remaining insurers raised premiums substantially on average to match their costs. Our analysis of insurer financials showed the market was stabilizing by 2017 and insurers were starting to become profitable in the individual market for the first time under the ACA. Signs pointed toward the 2017 premium increases being a one-time market correction. However, premiums increased again in 2018, in large part compensating for uncertainty around the ACA repeal debates in Congress and the Trump Administration’s termination of cost sharing payments.

While the vast majority of exchange consumers receive subsidies that protect them from premium increases, off-exchange consumers in ACA-compliant plans bear the full cost of premium increases each year. In 2017 and 2018, states that had larger premium increases generally saw larger declines in unsubsidized ACA-compliant enrollment (Figure 6), suggesting a possible relationship between premium hikes and enrollment drops.

Going into 2019, premiums held mostly flat on average but the individual mandate penalty was reduced to $0, effectively doing away with the ACA's requirement to purchase health insurance. Despite the lack of penalty, subsidized enrollment largely held steady. We estimate enrollment in unsubsidized off-exchange ACA-compliant plans declined by about 400 thousand from 2018 to 2019 (corresponding with the effective repeal of the individual mandate penalty but also relatively flat premium growth), which is smaller than previous declines in this part of the market that corresponded with steep increases in premiums.

Discussion

The effective repeal of the individual mandate penalty has raised concerns of enrollment declines in the individual market, particularly among people who are healthier than average. Expanded options to purchase loosely-regulated short-term health plans were also expected to siphon away healthy people, pushing premiums up a bit further for ACA-compliant plans on and off the exchange.

While the effective repeal of the individual mandate penalty and expanded access to loosely-regulated plans had an upward effect on 2019 premiums, other factors (like prior over-pricing) had a downward effect and resulted in average 2019 premiums being similar to 2018. We find that, while enrollment in the individual market has declined somewhat in early 2019, there are signs that enrollment may stabilize after a couple turbulent years.

There are many possible reasons for changes in enrollment, including the state of the economy and the number of people eligible for job-based coverage or public programs like Medicaid, and it is outside the scope of this analysis to determine which factors are driving these changes or whether they have any net effect on the overall insured rate. Nonetheless, given continued strong financial performance by individual market insurers and enrollment that remains higher than before the ACA, there do not appear to be any signs of market collapse so far in the absence of the individual mandate penalty.

The majority of people on the exchanges receive subsidies and are protected from premium increases, which in turn has a strong stabilizing effect on the individual market as a whole. As long as subsidies continue, the individual market will likely remain stable under current law. Nevertheless, middle-class people who do not qualify for subsidies will feel the brunt of any future premium increases. This is especially true of people with pre-existing conditions who likely would not qualify for short-term plans that base eligibility and premiums on people's health. So while there may be no signs of the

individual market collapsing, there remain concerns about affordability of coverage for people who do not qualify for a subsidy, many of whom have already left the individual market. The numbers also provide some perspective on the often hot debate over the ACA's marketplaces. More than 150 million people are covered through the employer market, 11 times the number covered in the individual market overall and 14 times the number covered through the marketplaces.

Methods
We analyzed publicly-available federal enrollment data from the Centers for Medicare and Medicaid Services (CMS), and insurer-reported enrollment and financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners (NAIC) and the California Department of Managed HealthCare. All total enrollment figures in this data note are for the individual health insurance market as a whole, which includes major medical insurance plans sold both on and off exchange.

Exchange and compliant enrollment are from the Centers for Medicare and Medicaid Services (CMS). Total individual market enrollment is from administrative data insurers report to the National Association of Insurance Commissioners, and compiled by Mark Farrah Associates: annual enrollment is from the Supplemental Health Exhibit and first quarter enrollment is from the Exhibit of Premiums, Enrollment, and Utilization for health companies and rolled over from the prior year Supplemental Health Exhibit for life companies. Off-exchange enrollment is estimated by subtracting exchange enrollment from total enrollment in the individual market. Non-compliant enrollment is estimated by subtracting compliant enrollment from total enrollment in the individual market. CMS does not collect enrollment data for off-exchange ACA compliant plans in Massachusetts or Vermont; in these states, non-compliant enrollment was estimated by applying the national average share of non-compliant off-exchange members to statewide off-exchange enrollment.

Annual enrollment figures from 2011 – 2018 are average monthly enrollment. Quarterly enrollment figures in 2019 are effectuated enrollment (i.e., people who paid their first month's premiums). For 2015 through 2018, we assume the share of off-exchange enrollment in compliant plans in Q1 is the same as the share of annual enrollment in off-exchange compliant coverage. Data on the share of off-exchange enrollment in compliant plans in 2019 are not available, so it is assumed to be the same as the share in 2018. As described above, this assumption may be inaccurate given changes in policy that took effect in 2019 and could change the distribution of people signed up in off-exchange ACA-compliant coverage as opposed to non-compliant coverage.
The health-care law erased 44% of the coverage gap between many poor Americans without health insurance and the few rich Americans without it, according to a study the National Bureau of Economic Research distributed on Monday. The law's provisions, especially its broadening of Medicaid programs, closed coverage gap between whites and minorities by 27%.

POLITICOPRO

Nevada leads states seeing merit in running ACA exchanges
Victoria Colliver

Nevada will flip the switch on its own Obamacare marketplace within weeks, hoping to avoid a disaster like its 2014 exchange rollout while providing a test case for other Democrat-led states eager to take control of their insurance marketplaces.

Though the revived Nevada Health Link is debuting at an uncertain time, with the fate of the Affordable Care Act hanging in the balance in federal court, the effort under Democratic Gov. Steve Sisolak is driven by a desire to save money, lengthen enrollment periods and make other changes to the state's insurance market without having to work through the Trump administration and rely on the federal exchange Healthcare.gov.

Other states are watching closely: Pennsylvania and New Jersey just finalized plans to operate their own exchanges for 2021 coverage. New Mexico will follow, while Oregon is researching the option.

“There’s a lot of pressure, and I feel it,” Heather Korbulic, executive director of the Silver State Health Insurance Exchange, the state agency that runs Nevada Health Link. “We didn’t set out to trail blaze, but it’s kind of a product of the situation we had. We’re leading this charge and hopefully smoothing a much better trail for the people who follow behind.”

Nevada became a symbol for futility when its 2014 bid to launch an insurance exchange was crippled by technical problems officials blamed on their vendor, forcing Republican Gov. Brian Sandoval and other officials to scrap the effort and join Healthcare.gov. The drama over congressional Republicans' repeal-and-replace plans in 2017 delayed thoughts of reverting to a state-run exchange. But now, with premiums rising and technology improved, Nevada is trying again.

"We’re seeing the start of states being willing to innovate and trying to do exciting, positive things to make markets work better for their residents," said Stan Dorn, a senior fellow at the advocacy group Families USA.

The 12 state-based marketplaces already in operation date from Obamacare's early years and handle applications and enrollment for the individual and small group markets. Another 28 rely entirely on the federal platform, while the rest are hybrids. Idaho was the last state to switch to its own web site for ACA sign-ups, in 2015.

States opting to design and develop their own exchanges say the uncertainty around the health care law's future is all the more reason to have as much control as possible over their markets. Operating an exchange offers the flexibility to take steps like

establishing a reinsurance program to protect health plans with high-cost customers or extending the deadline for signing up for coverage to accommodate a surge in last-minute interest.

The technology also is better and much less expensive than it was six years ago, when the federal government and many state-run exchanges got off to a rocky, glitch-filled start.

“Having our own technology helps us protect New Mexicans while also allowing us on the state level to be responsive to whatever may happen,” said Jeffery Bustamante, interim CEO of beWellnm, the state exchange that is moving eligibility and enrollment to a state-run system for the 2022 plan year.

Nevada Health Link is preparing for a Sept. 4 "soft launch," which will allow consumers to register to activate their accounts. It will become fully operational on Nov. 1. The state last year inked a six-year, $24.4 million contract with the vendor GetInsured for the effort.

Going solo made sense after state officials analyzed the federal ACA platform's planned increases in user fees. They project $5.5 million in savings for 2020 and $19 million over the life of the contract with GetInsured — money that they said would be poured back into operations.

Perhaps more important to Democrat-run states is the ability to craft a range of policies to counter Trump administration moves to weaken exchanges, which have included cutting money to spur enrollment and promoting skimpier but cheaper health plans as an Obamacare alternative.

A study last year found some evidence that premiums rose slower in states that run their own exchanges. This year, enrollment was up slightly in most state-run marketplaces and down in the majority of states that use the federal site.

Pennsylvania, with a liberal governor and conservative legislature, opted to run its own exchange based on practicalities and projected cost savings. The state estimates that it could launch the marketplace in the fall of 2020 for as little as $30 million — far less than the $88 million the federal government is projected to charge that year. Part of the difference would fund an envisioned reinsurance program.

Switching to a state-based exchange gained currency in New Jersey after Democratic Gov. Phil Murphy succeeded Republican Chris Christie. The state plans to levy a 1 percent assessment on insurers selling policies on the exchange and use the proceeds to fund $2 million in navigator services to promote enrollment during the coming enrollment period. To speed up its transition, the state will take control of the exchange while continuing to rely on the federal platform until the 2021 plan year.

Ray Castro, health policy director for New Jersey Policy Perspective, a public policy think tank, said the state's goal is primarily to reduce the number of uninsured. As for the future of the ACA, Castro was philosophical.

"This is life in the ACA. Every year, there's something new that threatens it," he said. "If we were to worry about that, we would have never gotten anywhere."

THE WALL STREET JOURNAL.
WSJ

Health Insurers Set to Expand Offerings Under the ACA
Anna Wilde Mathews

Insurers are expanding their Affordable Care Act plan offerings for next year, with the once-troubled business now generating profits, even as the overall individual-insurance market has shrunk.

Oscar Insurance Corp. is the latest to announce its expected growth for 2020, adding six new states, including Pennsylvania and Georgia, to its current roster of nine. Insurers including Cigna Corp. , Bright Health Inc., Molina Healthcare Inc. and Centene Corp. , the biggest seller of ACA plans, also plan larger footprints next year. Anthem Inc. is expanding in at least two of its states, California and Virginia.

The insurers' moves reflect the improved finances of the business after sharp rate increases in previous years helped revenue catch up to claims costs. Premium increases for 2020 so far appear likely to be moderate in many markets, after rates were relatively flat or even down this year, analysts and insurers said.

"The market is now clearly stabilizing," said Mario Schlosser, chief executive of Oscar. Oscar has proposed premium decreases in three states for next year.

Health Insurers Plan To Expand Affordable Care Act Offerings

Teri Goodrich, a 61-year-old engineer in Raleigh, N.C., said she was forced to drop her ACA coverage in 2017, when the premiums became unaffordable and she made too much to get a federal subsidy. Ms. Goodrich, whose income fluctuates as she takes on consulting work, got a subsidy the following year that made ACA insurance affordable, and has stayed covered even without a subsidy this year.

But, she said, her current consulting contract will end later this fall, and she may drop her ACA coverage again then. Without the federal tax credit, "the insurance premiums are superhigh," she said.

The lack of overall growth in the ACA market is likely one reason large national insurers that pulled out in past years are remaining on the sidelines for 2020, said Deep Banerjee, an analyst with S&P Global Ratings. Also, they are likely able to get stronger results from other lines of business, he said.

UnitedHealth Group Inc. said it expects to be in the same three ACA markets next year as this year. CVS Health Corp. 's Aetna and Humana Inc. both said they have no plans to offer ACA products in 2020.

But companies that are currently in the ACA marketplaces said they want to expand, despite lingering risks like a court challenge to the law filed by a group of Republican-led states. Many ACA plans keep costs down with smaller selections of health-care providers, with some insurers, including Bright and Oscar, often building plans around a single major hospital system. Both Bright and Oscar said they are seeing increased interest from health-care providers in offering such plans.

Health care costs as much as a new car
Drew Altman

Buying a new car every year would be a very impractical expense. It would also be cheaper than a year's worth of health care for a family.

Why it matters: The cost-shifting and complexity of health insurance can hide its high cost, which crowds out families' other needs and depresses workers' wages.

By the numbers: Health care for a family covered by a large employer cost, on average, $22,885 last year.

- That's $2,000 more than the sticker price for a brand-new Volkswagen Beetle.
- If the iconic Beetle isn't your style, $22,885 would also be more than enough to get you a Ford Focus ($17,950), a Toyota Corolla ($18,600) or a Hyundai Sonata ($22,050).
-

Between the lines: Roughly $15,000 of that $22,885 comes from employers' contribution to their workers' premiums. That share alone is enough to buy a basic sedan.

- Workers chip in an average of $4,706 per year premiums, and then spend an additional of $3,020 out of pocket. Combined, that's almost 4 times more than the average family spends on gas in a year.

The Beetle is being discontinued in the U.S. after this year. But as health care costs continue to rise, they'll be comparable to even fancier cars. They're already inching up toward the cheapest Cadillac — a familiar car metaphor.

- The Affordable Care Act's "Cadillac tax" was intended to put downward pressure on prices by taxing the most generous health plans. But it actually affects a broad range of plans, and Congress has delayed the tax until 2022. The House has voted to repeal it altogether.

POLITICOPRO

Lawmakers push for health care expansions at end of session
Angela Hart

SACRAMENTO — As the rising cost of health care dominates policy debates in the Capitol, California lawmakers this year are considering eight measures that would add to that price tag by expanding coverage requirements.

Proposals moving through the Legislature would mandate that state-regulated insurers and health plans cover fertility preservation, hearing aids for people under age 18, virtual office visits and new therapies to treat cancer and autism.

They'd also further expand Medi-Cal offerings after Gov. Gavin Newsom and lawmakers already agreed this year to restore optional benefits cut during the recession at a cost this year of $56 million.

Additional proposals on tap would require Medi-Cal to cover blood glucose monitors for people with diabetes, medication management to help ensure people take their prescriptions and extended services for women with postpartum mental health conditions.

Annual costs to implement the new coverage mandates — for Medi-Cal patients and those enrolled in private coverage — would be nearly $300 million, shouldered largely by businesses and patients in employer-based or other private health coverage, according to analyses by the California Health Benefits Review Program.

State spending would also grow, with unspecified "millions" in added costs to the general fund, according to legislative fiscal analyses. Some of the measures would also result in greater federal spending.

The benefit expansions present an expensive dilemma for California lawmakers and Newsom, who have sought to make the health care system more inclusive and accessible, with an eye toward preventative care. But those health system improvements add to the cost of health care, and Democratic leaders have not identified concrete ways to lower or control rising costs in the public-private realm.

The budget Newsom signed into law this year does, however, include higher incentive payments for providers who meet additional value-based quality measures aimed at improving care and containing spending for high-cost, high-need populations.

Bill authors say the proposals are worthy investments that could ultimately drive down costs by improving patient care before conditions or treatments grow more costly. They also argue upfront cost increases to taxpayers, employers and their workers will help improve the quality of life for patients.

"We believe it’s actually going to save money," said state Sen. Anthony Portantino (D-La Cañada Flintridge), speaking about one of his bills aimed at helping cancer patients preserve eggs or sperm as a result of invasive cancer and other treatments that can lead to infertility.

"Often times people will forego treatment, and as patients get sicker, they'll require more treatment, more expenditures, more health care," Portantino added. "If you store their fertility from the get-go, they'll feel better about entering into chemotherapy and other cancer treatment and get cured quicker, and insurers will save money in the long run."

Assemblyman Richard Bloom (D-Santa Monica), author of a bill that would require private insurers and health plans to cover hearing aids for people under age 18, said though insurance companies would see higher costs, consumer spending would actually decline.

"The cost of hearing aids is upwards of $5,000, and in many cases Medi-Cal will cover those but if you’re caught with a policy that does not, it becomes a very significant out-of-pocket expense," Bloom said. "And the costs are hidden for those who will not have the benefit of hearing aids. Their lives will be forever effected."

The nonpartisan CHBRP analyses found that although costs to employers and patients would rise for some of the proposals, public health would improve, as would the quality of life for individual patients.

The hearing aid benefit, for example, would improve a child's ability to learn and help them get and retain jobs throughout their lives. Expanded telehealth services would help patients get more timely access to primary and specialty care. And people with access to medical devices and treatments for cancer could have longer lives.

Health insurance companies argue now is not the time to create new health care mandates.

"We remain concerned about the cumulative effects of benefit mandates on premiums," said Mary Ellen Grant, spokesperson for the California Association of Health Plans, which opposes four of the eight bills because they'd add mandates on private plans and insurers.

"We think it's important for lawmakers to look at them cumulatively," she added. "They have to take into consideration the fact that premiums need to stay affordable for Californians, especially when they're trying to provide coverage for the uninsured and expand coverage."

Here's a brief rundown of each of the eight bills. Cost estimates are based on legislative fiscal and CHBRP analyses.

— CA SB600 (19R) by Portantino: Requires state-regulated health plans and insurers to cover fertility preservation if a medically necessary treatment could lead to infertility. The state Department of Health Care Services says it would also be required to cover it in Medi-Cal for a state and federal cost that would "likely be in the millions of dollars annually." The bill would increase net annual employer and employee health care expenditures by $6.7 million.

— CA SB163 (19R) by Portantino: Broadens mandate for private insurers to cover medically necessary behavioral health treatment for autism. The state Department of Managed Health Care would see annual cost increases up to $850,000 to enforce the bill. It would increase net annual employer, employee and Medi-Cal health care expenditures by $4.3 million.

— CA AB744 (19R) by Assemblywoman Cecilia Aguiar-Curry (D-Winters): Requires health plans and insurers to reimburse providers for telehealth services as they would for in-person appointments and treatment. The bill would increase fees assessed on health plans. It would also increase net annual Medi-Cal, employer and employee health care expenditures by $278 million.

— CA AB598 (19R) by Bloom: Would require commercial health insurance policies issued or renewed after Jan. 1, 2020, to cover hearing aids up to $6,000 per pair. It would increase fees assessed on health plans and shift $13.6 million in out-of-pocket spending by patients to purchase hearing aids on to health plans and insurers. The bill would increase net annual employer and employee spending by $2.7 million per year.

— CA AB746 (19R) by Sen. Patricia Bates (R-Laguna Niguel): Would require health plans and policies that cover chemotherapy, radiation and other cancer treatments to also cover other anti-cancer therapies and medical devices. It's estimated this bill would, at the outset, cover five people using a device known as Optune. It costs an estimated $97,000 per person. The bill would result in an increase in net annual employer, employee and Medi-Cal costs of $648,000.

— CA AB848 (19R) by Assemblyman Adam Gray (D-Merced): Would add blood glucose monitors to mandatory benefits covered under Medi-Cal. The Department of Health Care Services estimates the total annual cost at $100.8 million in state and federal funds.

— CA AB1131 (19R) by Assemblyman Todd Gloria (D-San Diego): Would require Medi-Cal to also cover comprehensive medication management for total annual benefit costs of about $45 million in state and federal funding.

— CA AB577 (19R) by Assemblywoman Susan Talamantes Eggman (D-Stockton): Extends full Medi-Cal coverage for postpartum mental health conditions for up to 12 months for women who are undocumented or otherwise lose eligibility. Its estimated annual cost to the Medi-Cal system would likely exceed $10 million.

FierceHealthcare

CMS won't enforce its ACA copay accumulator plan in 2020
Paige Minemyer

The Trump administration will not enforce its copay accumulator policy for 2020 Affordable Care Act (ACA) plans amid confusion from stakeholders.

In April, the Centers for Medicare & Medicaid Services (CMS) finalized the annual rule governing the ACA plans including a provision that would block insurers from applying the value of drugmaker coupons to patients' out-of-pocket limits when a generic drug is available.

In an FAQ document (PDF) posted earlier this week, CMS' Center for Consumer Information and Insurance Oversight (CCIIO) said stakeholders warned that the rule was unclear on whether ACA exchange insurers would be required to apply the discounts to members' out-of-pocket costs in other situations.

As such, CMS said it elected not to enforce the plan in 2020 after consulting with the Labor and Treasury departments. The agency said it would address the conflicts in rule-making for the 2021 plan year.

The agency added that it received feedback that the policy would conflict with regulation from the IRS governing high-deductible health plans (HDHPs), another cause for concern.

"The departments understand that the policy advanced by the 2020 [Notice of Benefit and Payment Parameters] and prior IRS guidance related to HDHPs may conflict, and therefore the departments' interpretation of how drug manufacturers' coupons apply with respect to the annual limitation on cost-sharing is ambiguous," CMS wrote in the FAQ.

CMS said in the FAQ that it would also not penalize states that declined to enforce the policy.

Under a copay accumulator, drug manufacturers' coupons cannot be applied to pay down deductibles or copayments, and they're a growing tool for plans in the ACA markets as well as employer plans to shift additional costs to consumers.

These are controversial among patient advocates and have been banned in some states including Virginia and West Virginia.

In response to the FAQ, the AIDS Institute called the reversal "disappointing." The group had previously celebrated the policy as a big win, interpreting the rule as banning copay accumulators in situations where patients did not have access to generic alternatives.

"Patients are complaining about high out-of-pocket costs for prescription drugs and rely on drug company copay assistance to afford them," Carl Schmid, the institute's deputy executive director, said in a statement.

"CCIIO's announcement is disappointing and will increase the cost patients must pay for their drugs, which is completely opposite of the administration's desire to lower prescription drug costs for patients," he said.

Bloomberg

Obamacare Refunds Could Hit $5 Billion on Eve of 2020 Election
Sara Hansard

Obamacare insurers are likely to refund as much as $1 billion to consumers in 2019 as a result of earlier overcharges. And in 2020 those payments, which would come around the time of the presidential election, could reach $5 billion.

That is the assessment of analysts who follow health insurers' claims payments. The 2019 refunds, made under the Affordable Care Act's "medical loss ratio" requirement, will probably average about $200 per individual or about $600 for a family of three, blog writer and ACA supporter Charles Gaba said in an interview.

Even as the Obamacare marketplaces show signs of stability with moderating premiums and increasing insurer participation in 2019 and 2020, the rebates also reflect the uncertainty that has surrounded ACA policies—including changes made during the Trump administration—since the law's inception in 2010.

Under the ACA's medical loss ratio requirement, insurers must spend at least 80% of premiums in the individual and small group markets on medical claims or quality improvements. If they spend less than that, they must refund the difference to consumers.

The refunds, made in the fall, cover health plans' medical loss ratios for the previous three years. So, the refunds consumers receive this fall, which could be in the form of credits for future premiums, will cover 2018, 2017, and 2016.

The rebates must be issued by Sept. 30. A spokeswoman for the Centers for Medicare & Medicaid Services, which oversee the Obamacare markets, said the agency expects to release the most recent data "in the coming months."

For 2017, insurers paid a total of $706 million, according to data compiled by Gaba. Between 2012 and 2016, total payments ranged from $332 million to $519 million.

'Confusion and Uncertainty'

The rebates are largely the result of overcharges in 2018, when most insurers raised prices on some plans to make up for the Trump administration withdrawing payments to cover subsidies for low-income people. Premiums went up sharply in 2017 as well, but those increases are attributed mainly to insurers correcting previous undercharges that didn't cover their costs for exchange coverage.

"In 2017 and 2018 there was a tremendous amount of confusion and uncertainty," Gaba said. In 2017 premium rates for individual coverage rose an average of 28%, and in 2018 they rose 31%, he said in a blog posting.

Among the actions taken by the Trump administration that "caused tremendous confusion" was the October 2017 decision withdrawing payments to insurers to cover cost-sharing subsidies that insurers are required to provide to low-income people, Gaba said. "A lot of carriers scrambled" to figure out what to do, he said.

In addition to raising premiums on some plans to cover the cost of the lost federal payments, many insurers raised premiums more broadly as well.

"They over-estimated in some cases," Gaba said. "Now they're basically correcting for that."

The CMS defended the actions of the Trump administration, which have been roundly criticized by Democrats and ACA supporters.

"The Trump Administration inherited a chaotic individual market," a CMS spokesman said in an email to Bloomberg Law. In 2017 many insurers left the market after premiums had more than doubled since before Obamacare's regulations took effect in states using the federal HealthCare.gov exchanges, the spokesman said.

"We've taken a number of important steps to promote stability and promote more affordable choices. As a result, premiums actually dropped this year and we're seeing issuers come back to the market," the spokesman said.

“Critics’ predictions that our actions would undermine the Obamacare market have clearly not materialized,” the spokesman said.

Reaction to Loss of Payments
Most insurers reacted to the loss of cost-sharing reduction (CSR) payments by raising premiums on silver tier plans. Premium subsidies are based on some silver tier plans, so the end result was larger subsidies for moderate income people who qualify for them.

“The CSR defunding made the market more attractive” to consumers who qualified for subsidies, Greg Fann, a consulting actuary with Axene Health Partners LLC of Temecula, Calif., said in an interview.

Insurers overreacted to the loss of the payments by raising rates too much in 2018, Fann said. In addition, they overestimated the impact of losing customers due to the repeal at the beginning of 2019 of the requirement that all individuals have health coverage, he said.

“They clearly overpriced for 2018,” said Fann, a fellow of the Society of Actuaries.

Likely Rebate Candidates
Insurers that face the least competition—and therefore are the most able to raise rates—appear to be facing the biggest rebate payments.

“Rural insurers with large monopolies and huge price increases in ’17 and ’18 are the most likely to have large rebates,” David Anderson, a research associate with Duke University’s Margolis Center for Health Policy, said in an interview. “Insurers in competitive markets are less likely to have large rebates.”

Among the companies likely to be sending out sizable rebates in 2019 is Capital BlueCross, based in Harrisburg, Pa., which expects to issue rebates totaling about $20 million, according to a company spokeswoman.

Premera Blue Cross Blue Shield of Alaska will pay $5.9 million to Alaskan consumers, Alaska Division of Insurance director Lori Wing-Heier said in an email. If the company continues to have a favorable financial experience in 2019, it will likely have to provide rebates in 2020, she said.

Premera, based in Mountlake Terrace, Wash., had slight premium increases in 2017 followed by a 22.4% decrease in 2018 and a 6.5% decrease in 2019, Wing-Heier said. In 2017 Alaska began a reinsurance program, which reduced premiums in the state by providing payments to insurers to cover high-cost claims.

Blue Cross and Blue Shield of Oklahoma, owned by the Health Care Service Corp., will pay rebates totaling $3 million in 2019 for the individual market and $10 million for the small group market, Mike Rhoads, the deputy commissioner of the Oklahoma Insurance Department, said in an interview.

The carrier was the only Obamacare insurer in the state in recent years, covering the entire state, until Medica joined the market in 2019, he said. In 2020 Bright Health will offer coverage in the Oklahoma City area.

In 2017 Oklahoma experienced rate increases of 40% to 50% in order to prevent health insurers from losing money, Rhoads said.

Health plans in the area “were hemorrhaging money” at that time, and “they had to right the ship,” he said.

Premium increases in 2018 there were more moderate, Rhoads said, and Blue Cross Blue Shield of Oklahoma’s individual market medical loss ratio for the 2016-2018 period is 79.3%, just below the 80% threshold.

L.A.’s Health-Care Reform Is a Lesson for Democrats
Ronald Brownstein

LYNWOOD, Calif.—The dozen elementary- and middle-school students who were practicing calisthenics, before they began a class on healthy eating, surely had no idea they were at the forefront of the debate over the future of health care in America. But the young people who gathered here last week for the Healthy Cooking for Kids session at the Lynwood Family Resource Center are part of what may be the country’s most thorough test in establishing a public competitor to private health insurance.

The Lynwood Center in this predominantly Latino neighborhood southeast of downtown Los Angeles is operated by the L.A. Care Health Plan, the nation’s largest public health-insurance company. L.A. Care was launched in 1997 by the state to manage the health care of Los Angeles County participants in California’s Medicaid program, known as Medi-Cal. But since 2013, it has also sold insurance to the general public through the state insurance exchange established under the Affordable Care Act. In the process, L.A. Care has directly competed with private health insurers for customers, exactly as many Democrats want a “public option” to do nationwide.

“The only income we get is the premium income,” John Baackes, L.A. Care’s chief executive officer, told me. “We don’t get a subsidy; we don’t get any special treatment; we have to go through all the same regulatory hoops that [private insurers] do. So I’m saying, ‘If you want to see what a public option looks like, come take a look.’”

Health care remains perhaps the most significant policy divide among 2020 Democrats, an issue that has infused two rounds of presidential debates and seems likely to do so yet again when the candidates convene in Houston next month. The field is split between the candidates proposing to move the country to a single-payer health-care plan that would eliminate private insurance (most vocally, Senators Bernie Sanders of Vermont and Elizabeth Warren of Massachusetts) and those who would establish a public option to compete with private plans.

Read: The Democrats' gamble on health care for the undocumented

The House passed a public option in the original version of the ACA in fall 2009, but the idea died in the Senate. Now the Democrats most vocally opposing single payer, such as former Vice President Joe Biden and Senator Michael Bennet of Colorado, rely heavily on a public option in their own health-care plans as a way to increase access to coverage and reduce cost.

The experience of L.A. Care shows the possibility of the public option to leverage change, but also the tough choices that loom in implementing the idea. The plan has created a sturdy competitor to private insurers, but it hasn't had a transformative effect on cost. L.A. Care "ended up being a good and lower-cost option, but it's not the revolution," Anthony Wright, the executive director of Health Access California, a consumer-advocacy organization, told me. "It shows both the potential and the limits of a public option."

L.A. Care's roots stretch back to California's decision in the 1990s to move most of its Medicaid population into managed-care programs. To run them, the state authorized counties to establish their own nonprofit, publicly operated health-insurance programs. As Wright told me, the thinking was that since much of the care for these low-income families would come through the public-health system of hospitals and clinics already run at the county level, it made sense to create a public-insurance plan to coordinate with them.

Los Angeles County, the nation's most populous, was one of several counties in the state that decided to do so. Though L.A. Care is tied to the county government, Baackes told me it operates "definitely at arm's length" from it, with only one L.A. County supervisor sitting on its board. Managing the medical benefits for Medicaid recipients in L.A. County became a big operation: L.A. Care now coordinates health care for just over 2 million people on Medicaid. After former President Barack Obama signed the ACA into law, L.A. Care won approval from the state to compete for non-Medicaid consumers in the insurance exchanges it established under the law. Today it is the only public-health-insurance plan operating on California's exchanges, serving about 80,000 consumers. That ranks it first among health-maintenance organizations selling on the exchange in L.A. County, and fourth among insurance plans overall.

L.A. Care entered the exchanges with a clear vision of its target audience: lower-income families transitioning between Medicaid and the general insurance market when they earned more than the Medicaid-eligibility cutoff (138 percent of the federal poverty line).

The pitch was that L.A. Care could provide continuity of care to people who moved back and forth across that divide: They could keep their same doctors when fluctuations in their income tipped them from Medicaid into the exchanges, or vice versa. “That was why we did it—for continuity,” Baackes said. “The thinking was people who may cross the line and earn a buck more than 138 percent, they’d lose medical eligibility, and if [they] were in the exchange, they could stay with L.A. Care, be eligible for a significant subsidy, and they’d still have access to care.”

As a public plan serving a predominantly low-income population, L.A. Care has developed an unusually holistic approach to health insurance. It has opened six family-resource centers, including the one in Lynwood, and plans to open eight more by the end of 2020. Each center offers dozens of classes each week to promote healthier living—from meditation and stretching to early literacy and domestic-violence counseling. Margaret Coins, who directs the Lynwood Center, told me that more than 800 people pass through it each week. “I have families who have been coming here since day one,” said Coins, who has worked at the Lynwood facility since it first opened in 2009.

L.A. Care is now moving toward more comprehensive services. It wants to coordinate more closely with other social-service agencies to ensure that customers are enrolling in benefits that they’re eligible for, from housing assistance to food stamps. It is training a corps of “community health workers” who will coordinate care for the minority of plan members with the most complex medical needs (the people who also generate the most expenses for any health insurer).

L.A. Care also interacts with medical providers in an unconventional way. Rather than paying providers for each visit or procedure (what’s known as fee-for-service), it offers them a fixed sum to cover all the health-care needs of each patient. That reduces the incentive for providers to maximize visits from patients and instead, as Baackes put it, encourages them to ask, “What’s the most efficient way to ensure they get the highest quality?”

For all these reasons, outside observers generally praise L.A. Care as a worthy model. Laurel Lucia, the health-care program director at UC Berkeley’s Labor Center, said the plan has demonstrated that a public option can effectively coexist and compete with private insurers. But, like Wright, she notes that the plan’s effect on medical costs has been evolutionary, not revolutionary. Not until this year was L.A. Care offering the lowest premiums on the ACA exchanges in L.A. County, and Baackes said another plan may be slightly less expensive next year.

L.A. Care can hold down costs because it doesn’t have to turn a profit and it has been innovative in trying to restrain expenses. But its ability to squeeze costs is limited by the fact that it is negotiating reimbursement rates with the same medical providers the private plans are using. “They are lower cost, but … it is not a dramatic difference from some of the private insurers, because at the end of the day, you have to contract with the same providers,” Wright said.

That dynamic points to what could be the most contentious issues for Democrats in any future attempt to create a nationwide public option. Many health reformers want a public option to reimburse doctors and hospitals at the rates paid by Medicare, which are much lower than what private insurers pay. Lucia told me that doing so would offer the best chance of significantly reducing national health-care costs.

Read: The real costs of the U.S. health-care mess

“If there could be an L.A. Care in every county … that would be an improvement, but it certainly wouldn’t be transforming our health-care system overall,” she said. “A national public option that pays providers Medicare rates would have much more dramatic effects on the overall health-care system.”

But many private insurance companies, with some reason, fear that a public option operating on such a reimbursement system would set the country on a path to a government-run, single-payer system. If a public option paid providers that much less, private insurers reason, it could charge much less than they do in premiums and ultimately siphon away most of the insurance market.

Baackes largely seconds the concern that a public option paying Medicare rates would undermine the private insurance market. “If it was set up that way, I’d be afraid of it too,” he said. Baackes is “making it my mission” to convince the private-insurance industry that it can coexist with a public option. But his vision of the public option, rooted in his experience with L.A. Care, is very different from the nationalized plan envisioned by many liberals. It would involve local plans established at the state, county, or city level that each negotiates its own agreements (and reimbursement schemes) with local providers. “There is something to be said about localizing them as much as possible, because then they are designed around local conditions,” he told me.

That model probably wouldn’t promise enough change for those who see the public option as the only opportunity, short of a single-payer system, to fundamentally transform the health-care system. But it might thread the political needle of offering enough change to satisfy reformers without provoking scorched-earth resistance from insurance companies and medical providers (not to mention some upper-middle-income patients who fear losing access to high-end doctors and hospitals).

Few Democrats today may want to hear it, but the compromises that led to the ACA, executed by Obama and his then–chief of staff, Rahm Emanuel, are what staved off a full-scale medical-industry uprising against the bill. And that was a large reason that Obama became the first president to pass legislation moving the nation toward universal health care, after Harry Truman, Richard Nixon, and Bill Clinton all tried and failed to do so. L.A. Care’s growing web of services for the families most in need may look like modest change compared with the calls from Sanders and others for a “revolution” in health care. But the steady gains evident in Lynwood may offer a more revealing preview of what the next Democratic president and Congress could likely achieve.

The New York Times

Which Health Policies Actually Work? We Rarely Find Out
Austin Frakt

A few years ago, Oregon found itself in a position that you'd think would be more commonplace: It was able to evaluate the impact of a substantial, expensive health policy change.

In a collaboration by the state and researchers, Medicaid coverage was randomly extended to some low-income adults and not to others, and researchers have been tracking the consequences ever since.

Rigorous evaluations of health policy are exceedingly rare. The United States spends a tremendous amount on health care, but very little of it learning which health policies work and which don't. In fact, less than 0.1 percent of total spending on American health care is devoted to evaluating them.

As a result, there's a lot less solid evidence to inform decision making on programs like Medicaid or Medicare than you might think. There is a similar uncertainty over common medical treatments: Hundreds of thousands of clinical trials are conducted each year, yet half of treatments used in clinical practice lack sound evidence.

As bad as this sounds, the evidence base for health policy is even thinner.

A law signed this year, the Foundations for Evidence-Based Policymaking Act, could help. Intended to improve the collection of data about government programs, and the ability to access it, the law also requires agencies to develop a way to evaluate these and other programs.

Evaluations of health policy have rarely been as rigorous as clinical trials. A small minority of policy evaluations have had randomized designs, which are widely regarded as the gold standard of evidence and commonplace in clinical science. Nearly 80 percent of studies of medical interventions are randomized trials, but only 18 percent of studies of U.S. health care policy are.

Because randomized health policy studies are so rare, those that do occur are influential. The RAND health insurance experiment is the classic example. This 1970s experiment randomly assigned families to different levels of health care cost sharing. It found that those responsible for more of the cost of care use far less of it — and with no short-term adverse health outcomes (except for the poorest families with relatively sicker members).

The results have influenced health care insurance design for decades. In large part, you can thank (or curse) this randomized study and its interpretation for your health care deductible and co-payments.

More recently, the study based on random access to Oregon's Medicaid program has been influential in the debate over Medicaid expansion. A state lottery — which provided the opportunity for Medicaid coverage to low-income adults — offered rich material for researchers. The findings that Medicaid increases access to care, diminishes financial hardship and reduces rates of depression have provided justification for program expansion. But its lack of statistically significant findings of improvements in other health outcomes has been pointed to by some as evidence that Medicaid is ineffective.

Although there are other examples of randomized studies in health policy, the vast majority have far less rigorous designs.

Some of them are sponsored by the Center for Medicare and Medicaid Innovation, created by the Affordable Care Act. It has spent about $1 billion a year on dozens of programs that pay for Medicare and Medicaid services in new ways intended to enhance quality and reduce spending. Most of the innovation center's pilots lack randomized designs, for which it has been criticized.

Also potentially problematic: Most of its programs rely on voluntary participation by health care organizations. There might be crucial differences between those that opt in and those that don't.

Mandatory participation poses its own set of challenges. "If you force a hospital to join a new program, but not its competitor down the street, you might put the hospital at an unfair financial disadvantage," said Nicholas Bagley, a University of Michigan health law professor. Also, testing voluntary participation makes sense if the program is never intended to be mandatory in the first place.

In considering a mandatory program, you also have to be mindful of politics.

"There will always be winners and losers," said Darshak Sanghavi, a former senior official for the Center for Medicare and Medicaid Innovation. "If losers are forced to remain in a program, that could cause a political backlash that might blow the whole thing up."

Randomization can also be challenging; it can be complex and hard to maintain. "A program with desirable features for evaluation, like randomization, that falls apart could be less valuable than one that was designed more realistically from the start," he said.

Problems can also plague rollouts that are voluntary and not randomized. Programs showing promise suffer from diminishing participation as health care organizations drop out. The innovation center's pioneer accountable care organization program offered health care organizations the opportunity to earn bonuses in exchange for accepting

some financial risk, provided they meet a set of quality targets. It started with 32 participants in 2012. Although studies showed it reduced spending and at least maintained, if not improved, quality, only nine remained by 2016 when the program ended.

Some of the largest innovation center programs — involving thousands of providers — bundle payments across services for some common treatments (like knee and hip replacements) instead of paying separately for each one. More efficient providers that can deliver the care for less than that price can keep some of the difference as profit. Those that can't lose money. Of six bundled payment programs, only one included random assignment.

Beginning in April 2016, Medicare randomly assigned 75 markets to be subject to bundled payments for knee and hip replacements, and 121 markets to business as usual. But the innovation center didn't maintain the design, announcing in November 2017 that hospitals could leave it. This will greatly limit what can be learned from the program.

Just as in clinical care, there are examples of incorrect thinking based on low-rigor studies that more rigorous ones later overturn. For example, many low-quality studies suggest that wellness programs reduce employers' health care costs as they improve health outcomes. But when the programs have been subject to randomized controlled trials, none of these findings hold up.

Hospital cost shifting — the idea that shortfalls from Medicare or Medicaid cause hospitals to charge higher prices to private insurers — can also seem commonplace from studies without rigorous designs. But when subject to more careful evaluation, the phenomenon is almost never observed.

An apparent preference for ignorance is not unique to health care. Policies across governments at all levels are routinely put in without plans to find out if they work — or how to unwind them if they don't, or how to build on them if they do. A 2017 Government Accountability Office report found that the vast majority of managers of federal programs were not aware of any recent evaluation of the programs they oversaw. In most cases, none had been done. In others, none had been done in the past five years.

It's hard to rid ourselves of ideas that are little more than wishful thinking or to end policies that don't work. The first step would be to do more rigorous policy evaluations. The next would be to heed them.

This App Saves Money On Prescriptions — And Shows How Messed Up Drug Prices Are
Jeffrey Young

If you're looking to save money on prescription medicines, there's a handy website and mobile app that can help you spend less. If America's pharmaceutical market weren't so crazy and confusing, it wouldn't need to exist.

According to the Centers for Disease Control and Prevention, nearly half of Americans use prescription medicines each month, and anyone who buys them already knows they can be incredibly expensive.

Enter the online retail drug discount company GoodRx, which launched in 2011 as a way to show consumers how to get their prescriptions filled at the lowest price. The company reports that 100 million people have used the service to find the cost of medicines at local pharmacies. The service, which is mainly intended for people without health insurance, is one of many drug discount programs available.

Thomas Goetz, director of research at GoodRx, said that what the Santa Monica, California-based company offers is transparency in a broken market. "When that transparency is in the hands of consumers, consumers start to change behavior," said Goetz. "And that starts to change the economics of the system. It's very slow-going, but that's in general what we're all about."

GoodRx's data makes it clear just how broken that system really is. HuffPost compared the costs for commonly used medicines at drugstores in 10 cities on the company's website and found head-scratchingly wide variances in prices.

Take, for example, four medications often used together by heart patients: atorvastatin, a cholesterol-reducing drug that's sold under the brand name Lipitor; lisinopril, a drug for high-blood pressure sold under the brands Prinivil, Qbrelis and Zestril; metoprolol, a medicine that treats high blood pressure and angina sold under the brands Lopressor, Kapspargo Sprinkle and Toprol-XL; and Xarelto, a drug that prevents blood clots and has the generic name rivaroxaban but is currently sold only under its brand name in the U.S. (These are the actual drugs that a patient HuffPost interviewed uses on a daily basis; we're not naming that individual for privacy reasons.)

We found that frequently the price of the same pills can be double or triple at one store what another store just miles away charges. In some cases, the highest price was more than six times the lowest price listed on GoodRx.

In only a few instances did one pharmacy offer the lowest price for all four medicines, meaning that patients seeking to spend as little as possible on those crucial drugs would have to visit multiple drugstores each month to refill their prescriptions.

That's what Amy McCallister, 50, of Quakertown, Pennsylvania, does. McCallister uses 13 prescription medications daily for a litany of health problems, including fibromyalgia, rheumatoid arthritis, migraines and chronic pain, which have left her too sick to work for the past nine years.

"I play the GoodRx game," said the former medical assistant and volunteer emergency medical technician. Most of her drugs are cheapest at Walmart, but a few are less expensive at CVS, McCallister said. "There's such a drastic difference in cost that it's worth it for me to drive the extra mile and a half," she said.

The pharmaceutical market is incredibly complex, even compared to the rest of America's byzantine health care system, and many factors help explain why a 30-day supply of 45mg metoprolol pills costs $3 at Fry's Food Store in Tucson, Arizona, but $12.48 at Walgreens. Examples of this sort abound in the data HuffPost examined from GoodRx.

The ZIP codes we used were for HuffPost's offices in New York, Los Angeles and Washington, D.C., as well as for Lebanon, Kansas (the geographic center of the contiguous United States); Tonopah, Nevada (the largest ZIP code by geographic area); Anchorage, Alaska; Clearwater, Florida; Lihue, Hawaii; Sioux Falls, South Dakota; and Tucson. GoodRx data is mostly limited to pharmacy and grocery chains. HuffPost gathered this information in July, so some prices may have changed since then.

Variations in costs are especially painful for patients who take high-priced brand-name drugs. For example, the prices on GoodRx reveal that in most places, the difference between the cheapest and most expensive options for Xarelto is relatively small; the biggest difference was in Sioux Falls where the highest price was 6.5% more than the lowest. But even that difference translates to around $25 a month, or about $300 a year, which is a lot of money for many Americans.

The prices for generic drugs are relatively low compared to those of brand-name medicines, but the GoodRx data show the range is much wider. In four cities, the highest price for atorvastatin was more than six-and-a-half times the lowest price.

For instance, the cheapest place to buy a one-month supply of atorvastatin near HuffPost's Washington office was $6 at a Harris Teeter grocery store and the most expensive was $45.37 at both Walgreens and Rite Aid. A patient filling their prescription at Walgreens and Rite Aid would spend $472.44 more each year than a patient going to Harris Teeter.

The question "How much does that drug cost?" rarely, if ever, has a simple answer.

For example, the average national price set by the manufacturers of atorvastatin was $8.57, according to internal data GoodRx shared with HuffPost, while the average price a patient would pay without insurance or discounts was $113.58. Using GoodRx at the pharmacy, that same medicine cost an average of $17.36.

The only price that matters to patients is the amount paid at the drugstore, of course. That varies greatly depending on whether they have health coverage and how good the benefits are. Pharmacy prices can differ from month to month, and what the customer pays at the counter can change each year with changes to insurance plans.

Behind all that is a complex set of deals between giant health care companies. Drugmakers set one price, and then pharmacy benefit managers, or PBMs, like Express Scripts and OptumRx negotiate that down for their clients (i.e., employers, insurers, policyholders and the government). Drugstores have their own prices for patients buying medicines without insurance, which typically but not always are higher than the lower prices available through discount programs like GoodRx.

Everybody along the way is trying to make a profit. But it's the pharmaceutical manufacturers that set the pace, said Len Nichols, director of the Center for Health Policy Research and Ethics at George Mason University in Fairfax, Virginia.

"There is no single villain here, but the first cause is always the list price," he said. "The PBM cuts their own deals with manufacturers and those deals flow through the system in such a way that some people find drug A is cheaper than drug B, and some people find exactly the opposite."

For example, the manufacturers' average list price for a one-month supply of 40 mg of atorvastatin is $2.07, according to data that GoodRx provided to HuffPost. A customer buying the medicine at a drugstore without using insurance or a discount program would pay an average of $18.04. And the average price paid without insurance but using GoodRx discounts is $9.13.

For many patients, it makes sense to set aside their insurance and pay the discounted cash price. It may be cheaper than their copayment, and consumers with high-deductible health plans may be better off each month paying a lower price at the pharmacy, especially those who don't expect to meet their deductibles in any given year. GoodRx reports that 70% of its customers have health coverage, compared to around 90% of Americans overall.

McCallister is covered by a private Medicare Advantage plan, but still opts to use GoodRx to pay out of pocket for her prescriptions, she said. The policy doesn't cover all her drugs, she said, and sets such high cost-sharing for others that the discounted prices from GoodRx and the pharmacies are lower.

Using the prices listed on GoodRx simplifies comparisons. GoodRx gets data from the pharmacies on the lowest prices available without using insurance. It identifies the least expensive versions of medicines, which often are manufactured by multiple companies,

at each store. The “coupons” the company provides aren’t actually coupons but facilitate the pharmacist’s filling the prescription with the exact version of the drug available at that low cost. The pharmacy then pays GoodRx a referral fee.

GoodRx says that it does not sell patient information and that it makes money by collecting fees from pharmacies and by selling ads on its website and subscriptions to GoodRx Gold, a paid service that offers deeper discounts. The company is privately held and doesn’t disclose its financials, but it was valued by an investment group at $2.8 billion last year.

The GoodRx method of saving money is different from the actual coupons offered by pharmaceutical manufacturers that insured patients can use to offset their copayments. The GoodRx prices sometimes work in conjunction with pharmacies’ in-house discount programs, which sometimes require customers to pay a subscription fee to access the cheapest price. In some cases, those programs result in patients paying $0 for medicines beyond the subscription fee.

In addition to the inscrutable complexity, the underlying prices of drugs are rising in the U.S., as is the amount everyone spends on prescription medicines.

Adjusted for inflation, per capita annual spending on prescription drugs was $90 in 1960, according to data from the Centers for Medicare and Medicaid Services. In 2017 (the most recent year for which data is available), per capita spending hit $1,025, a more than 1,000% increase over that 57-year period. Americans collectively spent more than $333 billion on prescription drugs in 2017, which amounts to 10% of total national health care spending.

Meanwhile, the amount that patients have to pay out of pocket has increased. In 2018, 85% of people with job-based health benefits had to meet an annual deductible before their insurance kicked in — an increase from 59% in 2008, according to a survey by the Henry J. Kaiser Family Foundation. And average deductibles have increased from $735 in 2008 to $1,573 in 2018. It’s also becoming more common for insured patients to have to pay “coinsurance,” or a percentage of the drug’s cost.

To McCallister, the bottom line is that drugmakers, insurance companies and pharmacies are forcing decisions to be made based on cost, not what’s best for the patient.

“They’re not the doctor,” she said. “It should be up to the doctor to give you what’s best.”

The Washington Post
Democracy Dies in Darkness

More Americans go without health coverage despite strong economy, Census finds

Amy Goldstein and Heather Long

The proportion of Americans without health insurance grew significantly last year for the first time this decade, even as the economy's strength pushed down the poverty level to its lowest point since 2001, according to federal data released Tuesday.

The findings that 27.5 million U.S. resident lacked coverage in 2018, based on a large U.S. Census Bureau survey, reverse the trend that began when the Affordable Care Act expanded opportunities for poor and some middle-income people to get insurance.

Taken together, the census numbers paint a portrait of an economy pulled in different directions, with the falling poverty rate coinciding with high inequality and the growing cadre of people at financial risk because they do not have health coverage.

As more Americans found jobs, the poverty rate fell last year to its lowest level since 2001 and middle-class income inched marginally higher. Median U.S. income — the point at which half of U.S. families more and half earn less — topped $63,000 for the first time, although it was roughly the same level as it was 20 years ago, after adjusting for inflation.

"Median household income today is right where it was in 1999. We've seen two decades with no progress for the middle class," said University of Michigan economist Justin Wolfers. "The economy is producing more than before, but the gains aren't being shared equally."

Incomes rose substantially in big cities last year but declined in smaller ones. And poverty rose for adults over 25 without high school diplomas.

"Some of the folks who fueled the Trump candidacy and presidency still aren't doing great," said Matt Weidinger, a fellow at the American Enterprise Institute who watches poverty trends closely.

With health care already a central issue in the 2020 presidential campaigns and a prime voter concern, meanwhile, the fresh evidence that insurance is slipping further out of Americans' reach is virtually certain to escalate partisan warring about Americans' access to affordable coverage.

Last year was the first time since 2009 that both the number and the proportion of Americans without coverage rose significantly from the year before.

The change was driven primarily by a decrease in public insurance for the poor, with enrollment in Medicaid dropping by 0.7 percent, the data show. The uninsured rate spiked especially among adults who are Hispanic and foreign-born. Coverage also dwindled among children who are Hispanic and naturalized citizens.

Health policy experts interpreted those patterns as evidence of a chilling effect from the Trump administration's efforts to restrict several forms of public assistance, including Medicaid, for immigrants seeking to remain in the United States. In addition, some state have been clamping down on eligibility rules for Medicaid.

"The word has gone out if you use Medicaid, then you are a public charge and you're liable not to get a green card," said Sara Rosenbaum, a George Washington University health law and policy professor, who called the patterns of health coverage for immigrant children "alarm bell territory."

"People are not only not enrolling, they are coming in [to Medicaid offices} and asking to be disenrolled." Rosenbaum said.

The Trump administration cheered the news that the official U.S. poverty rate fell to 11.8 percent last year (38.1 million people), the lowest since 11.7 percent in 2001, as a sign the president's policies are working to boost the economy. Businesses have been hiring minority and low-skilled workers at unusually high rates lately, helping give jobs and opportunities to Americans who struggled for years to get a chance.

"Employment is the best way out of poverty," said Tomas Philipson, acting head of Trump's Council of Economic Advisers. "President Trump's critics wrongly assert that government programs and handouts are the only way to lift people out of poverty, but today's data tells a different story."

The poverty rate for adults who work full-time all year round is 2.3 percent, much lower than the poverty rate for people who do not work, which is nearly 30 percent.

The fall in the U.S. poverty rate has been driven largely by people moving from part-time to full-time work, helping boost incomes. Last year alone, more than 2 million people found full-time jobs, the Census report said.

"We have found quite a big increase in full-time, year-round work that would tend to bring up incomes for working people," said Trudi Renwick, an assistant division chief at the Census Bureau.

But income inequality also remains near the highest levels of the past half century, according to census data. Recent wage gains by lower-income workers who have found jobs and benefited from minimum wage increases in many states have not been enough to close the long-running trend of the wealthy seeing far larger income gains than the middle or lower classes.

Incomes for families earning about $15,000 or less have fallen since 2007, according to the latest Census data, while incomes households bring in about $250,000 a year have grown more than 15 percent.

The Census' yearly data on health insurance, meanwhile, has been scrutinized by both supporters and opponents of the ACA as evidence of how well the law is working. Expanding insurance access was a main goal of the ACA, the statute forged by Democrats nearly a decade ago that has reshaped much of the health care system. President Trump and other Republicans contend the law is fatally flawed, while Democrats maintain it has been undermined by recent GOP policies.

The availability of insurance is influenced by a variety of factors, including economic conditions, because most insured residents get coverage through an employer. But as Trump works to dismantle the law and liberal Democratic candidates seek to replace it with a government-financed health-care system, both sides can find ammunition for their interpretation of why the nation's uninsured rate has started rising again.

Republicans point to how, as premiums escalate, fewer people buy health plans through the ACA's marketplaces unless they qualify for federal subsidies. Democrats point to how major tax changes, adopted by a Republican Congress at the end of 2017, eliminated the financial penalty for those who violate the ACA's requirement that most Americans carry health insurance — removing one motivation to stay insured.

Sen. Bernie Sanders (I-Vt.) a candidate who has long called for "Medicare-for-all," tweeted on Tuesday, "Mr. Trump lied. He promised to strengthen health care — instead, he has done everything he can to sabotage the Affordable Care Act. The result: Nearly two million people joined the ranks of the uninsured last year."

The new figures for 2018 show that the uninsured rate increased to 8.5 percent of the population from 7.9 percent the year before. In contrast, some 9 million Americans gained coverage between 2013 and 2014, the year that Medicaid expanded in many states and ACA insurance marketplaces opened for individuals and families unable to get affordable health plans through work.

Tuesday's data make clear that the contraction of insurance has been broad. Around the country, insurance coverage worsened in eight states and improved in three states. For the first time, the Census Bureau broke out the proportion of Americans buying health plans through the health law's insurance marketplaces. They show that 3.3 percent of people last year got their coverage through such a marketplace. The breakout reinforces how the ACA's health plans, while attracting considerable political attention, account for only a fraction of the nation's health insurance.

While Medicaid enrollment fell, the proportion of Americans covered through employer-based insurance did not change significantly. Meanwhile, enrollment in Medicare, the program for elderly and disabled people, grew slightly — probably as a result of the

nation's expanding population of older residents, Census officials said in releasing the data.

The Bureau's Current Population Survey is widely regarded as the most reliable portrayal of health insurance in the United States, but there have been other clues the ranks of the uninsured are swelling. In July, the U.S. Centers for Disease Control and Prevention issued findings from the National Health Interview Survey that the number of Americans uninsured at the same they were asked increased from 28.9 million in 2017 to 30 million last year.

The Census's CPS counts people as uninsured if they lacked coverage throughout the year.

Health-Insurance Consumers to Get $743 Million in Rebates Under ACA Rule
Anna Wilde Mathews and Stephanie Armour

Health insurers are expected to pay out a record $743 million to consumers this month under an Affordable Care Act rule that requires refunds if the companies don't spend a big enough share of premium dollars on health care.

The sum, which will go to about 2.7 million consumers who bought individual health policies from insurers, will be more than four times the amount paid out last year. The payout also dwarfs the next-highest total, $399 million in 2012, the first year of the refunds, according to a new analysis from the Kaiser Family Foundation, which calculated the total rebate payments by reviewing federal filings.

Healthy Rebates
This year, health insurers are making theirbiggest payout ever to people with individualinsurance, under an Affordable Care Actrequirement.

Consumers who get the rebates are expected to receive about $270 on average, but some policyholders could get as much as around $2,000. The payments, which will often come in the form of checks, must be sent to consumers by the end of September. For a family with a shared policy, the insurer issues one rebate.

Consumers will get the rebates even if most or all of their premium costs were covered by federal subsidies.

Insurers will pay out an additional $534 million to employers this year under the same ACA rule, and many employers are expected to pass along a portion of that to workers.

Under the ACA, insurers must spend the lion's share of the revenue they get from premium payments on health-care costs. For people who buy their own health insurance, if that proportion falls below 80%, the insurer must refund the difference to policyholders.

The large rebate total for 2019 largely reflects steep rate increases that took effect in 2018 for ACA plans, said Cynthia Cox, a vice president at the Kaiser Family Foundation. "It's really driven by individual market insurers in 2018 overpricing their plans," she said. The hikes bolstered insurer profits but overshot the ACA's guardrails.

The payments come as the future of the 2010 law remains in doubt, as the Trump administration backs a lawsuit from several Republican state attorneys general trying to strike down the entire health law. At the same time, some Democratic presidential candidates have backed replacing the law with a federal health-care system.

The issue could come up again during Thursday's Democratic presidential debate. Former Vice President Joe Biden wants to preserve and build on the ACA, widely known as Obamacare, while also adding an option where people could buy into Medicare. Sens. Bernie Sanders of Vermont and Elizabeth Warren of Massachusetts are pushing for Medicare for All, which generally would move every American, even those with employer-based coverage, to a government-run health plan.

Among the insurers with the biggest total expected payouts for individual plans are Centene Corp. , Health Care Service Corp., Cigna Corp. and Virginia-based Optima Health, which is owned by hospital system Sentara Healthcare.

The outlays aren't likely to have much effect on earnings because insurers have generally accrued for them in advance, said Matthew Borsch, an analyst with BMO Capital Markets.

"You file your rates assuming you're going to come in above that 80%," said Geoff Bartsh, a vice president at nonprofit insurer Medica, which is paying out about $14 million in individual-plan rebates. "We don't want to be in a position where we're sending out rebates. No one shoots to be there."

Mark Nave, a senior vice president at Highmark Inc., an insurer that is part of Pittsburgh-based nonprofit Highmark Health, said health costs in 2018 were lower than the company had projected when it boosted rates by 12% that year in Pennsylvania. Highmark will send out checks worth around $51 million in total to its individual policyholders in that state, in amounts ranging from $341 to $1,657.

"You've got limited information on the population you're insuring" when rates are set, he said.

Optima Health, which sparked local pushback for steep rate increases, will be paying out $99 million, with an average of $1,850 per individual policy. The insurer ended up getting a $94 million payment via another ACA program designed to smooth risk for

insurers, which it hadn't expected when it set its rates, said Dennis Matheis, president of Optima Health.

Ian Dixon, an app developer who founded Virginia consumer group Charlottesville for Reasonable Health Insurance, said the Optima Health rebates won't make up for the rate hikes local residents experienced. "They really don't compensate people for the overcharging," said Mr. Dixon. "It doesn't even come close." Mr. Matheis said he was "totally sympathetic with the consumers."

A spokesman for Health Care Service said the company exceeded the 80% threshold for the "vast majority of our customers in the states where we operate."

Cigna said it is sending out rebate checks to individual-market policyholders in five states and that they would be delivered by the end of September. Centene declined to comment.